mental health digest

National Clearinghouse for Mental Health Information, Vol. 2, No. 8, August 1970

mhd

MAYO CLINIC
LIBRARY
SEP 01 1970
ROC MINN.

## cover story

**Adoptive Grandparents**

**Students at Syracuse University are taking an active role in a mental health program for the elderly, as described in a story on page 53. This issue of the *Digest* also features several other reports on mental health of the aging.**

(Picture courtesy of the *Mental Health Communicator,* a publication of the Mental Health Information Program, School of Journalism, Syracuse University.)

## mental health digest

The *Mental Health Digest* is a monthly publication designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view. It contains condensations of material selected from the current mental health literature. The condensations are published with the approval of the authors and publishers for use in the *Mental Health Digest* only.

Material contained in the *Digest* does not necessarily reflect the opinions, official policy, or position of the National Institute of Mental Health.

Editorial Advisory Board

Bertram S. Brown, M.D., Chairman

Sidney Cohen, M.D.
John C. Eberhart, Ph.D.
Sherman N. Kieffer, M.D.
Gerald N. Kurtz
Morton G. Miller, M.D.
Gian C. Salmoiraghi, M.D., Ph.D.
Phillip L. Sirotkin, Ph.D.
Nathan Sloate
Louis A. Wienckowski, Ph.D.

Editor: Lorraine Bouthilet, Ph.D.

The *Mental Health Digest* is available on subscription from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. Subscription price: $3.50 a year; Single copy: 30¢. For foreign mailing, add $1.00. (No additional postage is required for Canada, Mexico, and Central and South American countries except Argentina, Brazil, British and French Guiana, Surinam, and British Honduras.) Please make check or money order payable to the Superintendent of Documents. An annual subscription runs for 12 consecutive issues and begins with the next issue following receipt of the order. Back issues may be ordered at the single copy price. The expiration date is printed on the top line of the address label. Change of address and complaints about non-receipt of issues should be sent to the Superintendent of Documents, and should include the old address, preferably a mailing label, as well as the new address.

Use of funds for printing this publication approved by the Director of the Bureau of the Budget, May 20, 1968.

# Mental Health of the Aging

The National Institute of Mental Health has a special interest in aging because elderly persons are particularly vulnerable to mental impairment. In the processes of aging, losses are suffered which may mean the old person loses the ability to control his own life in terms of obtaining the basic necessities of food, shelter, and clothing and of being with those persons who could be concerned for or interact with him. The decrements may include less physical mobility, organic deterioration which may affect his clarity of thought, bereavement through death of relatives or friends, retirement from life-long occupations and concomitantly a decrease in financial income and the loss of roles that were meaningful. Each of these losses can contribute to a feeling of insecurity and, therefore, to the status of the aged person's mental health.

Imposed on these losses, which differ in the degree of seriousness for each aging person, is his image to others in our youth and work-oriented society. Rejection faced by the physically healthy, aged person plus his own earlier feelings about "old people" have an impact on his adjustment to aging and on his mental health.

The NIMH is attempting to meet the mental health needs of the aged through programs which seek knowledge about mental health and mental illness through research, the training of professional manpower to perform services which will sustain and improve the mental health of older persons, demonstrations in State mental hospitals of ways to improve the mental health care of aged persons, and the development of community mental health centers both to treat and improve the mental health of aged persons.

The Section on Mental Health of the Aging in the Division of Special Mental Health Programs is responsible for coordinating the NIMH's efforts for the aging and stands in the role of advocate for programs for improving and sustaining the mental health of the aging both within and outside the Institute. Various techniques have been used to promote the development of programs to prevent mental health problems in the aging, including staff participation in conferences, meetings, institutes and workshops, and consultation with grantees and prospective grantees. These, plus liaison with other Federal agencies and other Divisions within NIMH, have been used to stimulate interest and activities in the area.

### Research

*Research to develop knowledge concerning the mental health and mental illness of aged persons*—A variety of investigations are being carried out in applied, behavioral, clinical, and psychopharmacological research. Among these studies are those concerned with environmental factors which may have an effect on the mental health of aged persons, the effect of retirement and withdrawal from life-long occupations, other psychosocial studies of adjustment of the aged, as well as studies of the terminal stage of life, and studies of persons already impaired living in the community and in institutions. Other studies are concerned with the "life crisis of retirement," a time when great changes take place to which adjustments must be made by the individual involved. Several studies are concerned with the psychosocial adjustment of the individual to the aging process. Some clinical research projects concerned with

sleep and dreaming have included specific studies which are of great relevance to aging persons.

*Research into the development of new kinds of delivery of services to improve or sustain mental health status of aged persons*—The whole problem of finding ways of helping support the mental health of aged persons and helping those aged persons already impaired has been difficult to solve because of lack of knowledge of how to prevent mental health problems and how to make up for certain internal and external losses taking place in the aging process. Among many studies, one was undertaken to find out how comprehensive services could be provided by the community, thus preventing mental hospitalization of older people. Another is concerned with developing and demonstrating improved methods of finding and reaching impaired older people and of serving them. This project is significant because it focuses upon an increasingly serious problem in urban areas and may provide answers as to types of services to be offered the impaired older person in the community as well as how to make use of already established agencies. Another study has the goal of learning whether the aged client can sustain his functioning in the community more effectively through the enhancement of services by a social work team.

**Hospital Improvement Program**

The Hospital Improvement Program was established in 1963 to help the States improve their hospital services to the mentally ill.

In the area of aging, most of these projects are aimed at reducing the length of stay for aged patients in mental hospitals through placement in the community, and/or to restore a greater degree of social functioning, and/or to provide physical rehabilitation services, and/or to develop more adequate means of screening the aged inpatient population. One project is designed to activate infirm patients and to provide a corps of personnel to take care of their psychiatric needs. It is of particular interest because of its aim to help and rehabilitate the hospital's most physically and mentally deteriorated patients. Another project aims to return a greater number of geriatric patients to the community. As a means of reaching this aim, the project works with the community, developing and making maximum use of community resources, educating the community, and establishing more adequate and intensive treatment programs in the hospital. Efforts have been made to prevent admission to the hospital where appropriate by attempts to work with patients to utilize other resources or ways of caring for the patient.

Another program includes hospital involvement in pre- and posthospital phases of treatment. The treatment program within the hospital focuses on the patient's physical condition, manifestation of chronic brain impairment, and psychological needs. Various treatment modalities are used, including physical rehabilitation and systematic memory training. The pre- and posthospital phases include consultation and screening before admission, discharge planning, and consultation after discharge.

**Training**

The development of manpower to meet the needs of the aged to prevent, or to help those persons already suffering, mental health problems is of critical importance. Unfortunately, the majority of persons interested in further professional training have not chosen to work with the aging. Two

grants have been given for continuing education in gerontology. One was made to the Gerontological Society. They propose to develop a meaningful continuing education program for individuals working in the field of gerontology. Their primary purpose is to improve and increase mental health services to the psychiatrically ill elderly, apply the most recent research data to practice, and stimulate interest and involve more professionals in conscious innovation of mental health services to the aged.

NIMH has attempted to stimulate training of new types of paraprofessionals to work with the aging in light of studies which indicate that certain important functions can be performed by nonprofessionals which will prevent institutionalization of the aged and help enhance the terminal years.

**Community Mental Health Centers**

Much hope had been expressed that the community mental health centers would be of assistance in helping the aged sustain themselves in the community. However, with the myriad problems that the centers face in staffing and serving those who, in cost benefit terms, may yield a higher return (e.g., the man who can go back to work with psychiatric help and thereby support himself and family) as compared with the aged person who may continue to need supportive help and care for the rest of his life, the actual investment of resources in staff has been limited. There are a few programs in the centers which give special attention to the aged.

The Section on Mental Health of the Aging has made itself available for consultation to community mental health centers through the Regional Offices in an attempt to raise the priority for care of the aged in the centers.

**Health Insurance and Medical Assistance**

NIMH is concerned—in a consultative role—with the development and extension of mental health services through health insurance and medical assistance programs. The primary goal is to make benefits for the mentally ill comparable to those available to persons with other kinds of illness. Implementation of standards for delivery of quality care, encouragement of additional resources, and new approaches to service delivery are major concerns. To assess the effects of the recent Federal legislation on the care of the mentally ill, a study was done of the utilization of mental health facilities by the aged. A study is underway of the types and availability of alternative methods of care for the geriatric long-term patient usually found living in public psychiatric institutions. In cooperation with the Bureau of Health, Social Security Administration, and the Community Health Service, NIMH undertook a thorough review of the certification of the psychiatric hospitals under Medicare. This has resulted in the involvement in planning for changes in the special psychiatric requirements as well as planning for in-depth training programs for the State survey personnel.

Workshops have been held for NIMH regional office staff members who are specifically concerned with Health Insurance and Medicaid. Also participating in these sessions were other NIMH personnel, Community Mental Health Service personnel, and the Social and Rehabilitation Service staff interested in Titles XVIII and XIX. Resource materials have been distributed to both Regional offices and State mental health authorities concerning policies and standards of care.

# Observations on 750 Geropsychiatric Patients

Imre Kopits

Since its establishment in 1794, Spring Grove Hospital in Baltimore has provided institutional care for elderly patients. The Geriatric Division contains 750 elderly patients (450 males and 300 females). About 250 elderly patients must be accommodated in the other five divisions. Presently the capacity of the hospital is 2,500 beds; of these, about 1,000 are occupied by patients over 60 years of age.

### Medical-Surgical Problems

In this study, attention was focused on the chronic disabling diseases. More than one condition was often present simultaneously, e.g., diabetic patients frequently had arteriosclerotic heart disease.

The *cardiac condition* usually developed on an arteriosclerotic basis, as established by means of physical examination, an electrocardiogram, and chest roentgenogram. The significance of the cardiocerebral circulatory relationship is well known and readily explains the high incidence of chronic brain disorders among aged patients.

*Crippling* was caused by various factors, such as congenital deformities, functional disabilities due to chronic arthritis, post-traumatic deformities, the sequelae of poliomyelitis, alcoholic polyneuritis, hemiplegia due to cerebrovascular accidents, paraplegia due to lesions of the spinal cord, and amputation due to injuries or diabetic gangrene.

*Diabetes* needs special consideration. The difficulties of maintaining a strict diet in mentally normal patients are well known. These difficulties are magnified in mental patients, who tend to cheat frequently. Separate wards for diabetic patients were organized with a common dining room where about 25 diabetic males and about 50 diabetic females received their meals. Urine was checked three times daily on the ward and once a week in the laboratory. The level of fasting blood sugar was determined at least once a month, and more often if necessary, since an unstable level is common among mentally ill diabetic patients with their labile moods.

Since *blind* and *deaf* mentally ill patients have lost direct contact with the environment, they are prone to paranoid ideas. By means of a cataract operation or appropriate lenses, vision can be improved. With the help of hearing aids, hearing often can be corrected. Paranoid tendencies subside gradually as a result of the correction of impaired visual and auditory functions. The treatment of *mute* (aphasic) patients or those with severe speech defects is difficult and requires special techniques.

There was a high incidence of chronic diseases of the respiratory system, gastrointestinal tract, skin, female genitalia, and male genitourinary tract.

Disease processes in the *oral cavity* need special attention. Most patients had poor oral hygiene; many were edentulous. Once the patients are provided with dentures, they improve in their eating habits and regain some of their self-esteem.

Disabilities of the *locomotory system* also have psychiatric relationships. Physiotherapy plays an impor-

Condensed with permission from the *Journal of the American Geriatrics Society*, 18(5), 353–363, 1970.

*Table 1—Psychiatric Diagnoses*

| Diagnoses | Percentage |
|---|---|
| Chronic brain syndromes | 52.5 |
| Presenile dementia (Alzheimer, Pick, Huntington) | 2.6 |
| Convulsive disorders (with or without brain injury) | 4.4 |
| Central-nervous-system syphilis | 5.9 |
| Intoxication (alcohol and drugs) | 6.1 |
| Senile brain disease | 7.5 |
| Cerebral arteriosclerosis and other circulatory disturbances | 26.0 |
| Mental deficiency | 10.0 |
| Mental deficiency without psychotic reaction | 3.3 |
| Mental deficiency with psychotic reaction | 6.7 |
| Psychogenic disorders | 37.5 |
| Paranoid reactions | 1.5 |
| Involutional and affective reactions | 8.0 |
| Schizophrenic reactions (various types) | 28.0 |
| Total | 100.0 |

tant role in rehabilitation. Some embittered, wheelchair-confined patients later walked with a steady gait and were emotionally well balanced by the time they left the hospital. Also, many diabetic patients were saved from gangrene by intensive physiotherapy.

We believe that somatic diseases, surgical procedures, and trauma, although not primarily etiologic factors in the development of mental illness, contribute to the triggering of latent psychotic disorders. This holds true especially in the field of geriatrics.

**Psychiatric Problems**

The official classification of the American Psychiatric Association was used to evaluate the 750 elderly mental patients (Table 1).

Some explanation is necessary concerning the patients belonging to the mental deficiency and psychogenic disorders groups. When these patients were admitted to Spring Grove State Hospital in their youth, their cases bore these mental diagnoses. For various reasons the patients remained in the hospital 30 years or more. Gradually, their original mental condition was overlapped by organic changes in the brain, usually cerebral arteriosclerosis. This may be better understood by observing the frequency distribution of patients by age and length of hospitalization (Tables 2 and 3).

Table 3 shows the time that had elapsed since the patient's admission to this hospital from 1906 through 1965. The number of males surpassed that of females until 1961, when the distribution of sexes was reversed.

**Social Problems**

Patients who were admitted in their youth, i.e., in the first quarter of this century, were classified chiefly in the categories of either mental deficiency or psychogenic disorders, whereas patients who were admitted recently, at an advanced age, were classified in the larger group of chronic brain syndrome.

*Table 2—Distribution by Age and Sex*

| Age Group (years) | Percentage of 450 Males | Percentage of 300 Females |
|---|---|---|
| 50 and below | 4.7 | 2.0 |
| 51 to 55 | 6.2 | 3.4 |
| 56 to 60 | 12.7 | 6.0 |
| 61 to 65 | 16.7 | 12.0 |
| 66 to 70 | 17.3 | 14.4 |
| 71 to 75 | 17.0 | 19.4 |
| 76 to 80 | 13.3 | 16.4 |
| 81 to 85 | 6.4 | 16.0 |
| 86 to 90 | 4.4 | 8.0 |
| 91 and above | 1.3 | 2.4 |

*Table 3—Length of Hospitalization*

| Five-Year Periods of Admission | Percentage of 450 Males | Percentage of 300 Females |
|---|---|---|
| 1906–1910 | 0.2 | 0.0 |
| 1911–1915 | 1.5 | 1.0 |
| 1916–1920 | 3.7 | 2.6 |
| 1921–1925 | 2.6 | 1.3 |
| 1926–1930 | 2.4 | 1.6 |
| 1931–1935 | 6.8 | 9.0 |
| 1936–1940 | 8.6 | 8.9 |
| 1941–1945 | 9.9 | 4.3 |
| 1946–1950 | 7.0 | 8.3 |
| 1951–1955 | 8.1 | 7.3 |
| 1956–1960 | 12.4 | 8.0 |
| 1961–1966 | 36.8 | 47.7 |

Our mentally deficient patients have been under institutional care since childhood. They did not have schooling, they performed no useful work, and they never earned a livelihood.

To the group of psychogenic disorders (with the exception of involutional reaction) belong the old "burned out" schizophrenic patients, most of them European single male immigrants who came to the United States in the early 1900's as unskilled laborers. They had lost all contact with their families in their native countries, and never adjusted to their new environment. These circumstances facilitated the development of schizophrenic reactions. Since these patients were hospitalized in their early 20's, they did not contribute to the economy but received support from public funds.

The latest group includes all cases of chronic brain syndrome involutional reactions which developed in old age. These patients were admitted at an advanced age. Most men were skilled workers who supported their families for 30 to 50 years. The female patients were housewives, mothers, and sometimes wage earners. These patients were productive and useful citizens. Yet due to organic changes in the brain, mental disorders developed. Their current mental condition is characterized by emotional instability, mental confusion, disorientation, impaired memory, progressive intellectual deterioration, and in some cases, by overt psychotic symptoms such as paranoid delusions or delusions of grandeur, or by hallucinations in the auditory and visual fields.

Cerebral arteriosclerosis and senile changes in the brain do not make hospitalization imperative. Factors that provoke emotional stress must be considered. In most cases sudden changes in habitual life patterns may act as "stress provoking" factors.

Regression in elderly patients may go as far back as early childhood. In severe cases, incoherent and irrelevant talk may become unintelligible mumbling. The patients lose contact, first with current events, and later with their immediate environment. Gait and posture become unsteady, the patient is confined to a wheelchair, and finally bedridden. Often voluntary movements are uncoordinated and the patient must be restrained to avoid injuries. Control of sphincter muscles disappears and the patient becomes incontinent. When a tongue-depressor is introduced in the mouth of an elderly deteriorated patient, he may react with a sucking reflex.

In cases of severe intellectual and physical deterioration, the patients become unmanageable, not only in their family environment, but in a nursing home. In such cases hospitalization is imperative. Since the patient's condition is irreversible, the hospital can offer nothing but nursing care and medical treatment for the prolongation of life. These patients die from intercurrent somatic diseases such as

cardiac failure, pneumonia, or a cerebrovascular accident.

Earlier admission to the hospital would have made it possible for many patients to receive effective medical and psychiatric treatment as well as rehabilitative nursing care. Many could have been saved when their condition was still reversible. The false image laymen have of mental institutions prevents early admission. Sometimes even after admission, the relatives express guilt feelings for having brought them to a mental hospital.

In mild cases, and when patients with chronic brain syndrome are admitted early, the outlook is not as hopeless as it was in the past. It depends upon the interplay of the patient's medical and mental conditions and his social background. It is important to explain the social factors to relatives, pointing out their share in rehabilitating the patient. Before the patient's release from the hospital, they are warned about the necessity of understanding him at home and of providing him, above all, with "tender loving care."

**Treatment**

Treatment was relatively successful with these patients. Hospitalization was the first essential step. From the moment of admission, the patient is removed from his home, separated from his family, and temporarily isolated from his daily problems. He is placed in a new surrounding, with new persons (physicians, nurses, social workers, other patients) and follows a new routine. Often the newly admitted persons adjusted surprisingly well. Many needed psychotropic drugs—tranquilizers or stimulants.

In relation to modern psychopharmacology, an important factor should be mentioned. Most effective tranquilizers decrease the arterial blood pressure and may temporarily diminish the blood supply to the brain, mostly in the so-called "border zones" between the anterior, middle, and posterior cerebral arteries. Thus, tranquilizers must be used with caution in aged persons.

We avoid the use of barbiturates for insomnia. Our choices were chloral hydrate and glutethimide in small doses or methyprylon. Among the antiparkinsonian drugs, the most effective was biperiden and it had no significant side effects. Among the psychic energizers (or antidepressants), good results were obtained with imipramine, pentylenetetrazol combined with vitamins, methylphenidate and pipradrol with vitamins. Anticonvulsant drugs were phenobarbital, diphenylhydantoin, and primidone. Drugs are of great value in alleviating tension or eliminating depressed mood, thus making the patient accessible for psychotherapy.

Because of the large number of patients, individual psychotherapy could not be carried out, but satisfactory results were obtained with group psychotherapy. In all wards of the Geriatric Division, group meetings were held under the leadership of the nursing personnel and social workers. For the groups under my supervision, I chose mostly patients without relatives, to prepare them for placement by our Social Service Department in foster or nursing homes. One social worker regularly attended group meetings and at the end of each session we discussed the behavior of our patients during the meeting. Two or three patients were released monthly and replaced by the next best candidates.

Our objective was to follow a team approach. The team included psychi-

atrists, physicians, nurses, psychiatric aides, social workers, volunteer workers, and members of the clergy. Well trained in pastoral psychiatry and with many years of experience with the mentally ill they are helpful in preadmission counseling and in providing religious services for patients in the hospital. Also, they are able to find adequate housing for some patients at the time of discharge.

The Social Service Department has the leading role in placing patients in nursing and foster homes. It is also engaged in preadmission counseling, postadmission followup, interim work, preconvalescent leave, placement in nursing homes, and visiting patients upon their release from the hospital.

Through a continuous contact procedure, many families were persuaded about the ability of the patient to return home and to be accepted there. If a family was unable or unwilling to accept an elderly patient, it helped in the effort of his placement in a nursing home or foster home. Patients were released on "convalescent leave" and followed by a staff psychiatrist in the out-patient clinic. If the patient functioned satisfactorily in the community (family home, foster home, or nursing home), he was discharged from the hospital records 1 year after his release.

As a result of this approach, we were able to increase the number of discharges, despite the rising number of admissions. Because of our intensive joint efforts at rehabilitation, the yearly proportion of discharges to admissions has risen more than threefold, i.e., from 20 percent to 69 percent through 1966.

# Misplacement of the Elderly in Geriatric and Psychiatric Hospitals

G. E. Langley and J. H. Simpson

The simultaneous occurrence of mental and physical illness in elderly patients and the difficulties that arise when psychiatric and geriatric facilities are in separate hospitals have suggested the need for combined Psycho-Geriatric Assessment Units. The imminent provision of such a unit in the Exe Vale Hospital, Exeter, led to the review of inpatients recently admitted to the Geriatric and Psychiatric Hospitals. Patients from Exeter were chosen for this study.

We selected only cases admitted within 6 months of the date of the survey. All patients were over 65. On 2 days set aside for the purpose, the investigators recorded in their units the age, sex, marital status, mental and physical diagnosis, and hospital unit, of all the patients resident on one or other day. In all, 120 patients were studied, 90 females and 30 males. Each was rated along a scale specifying the proportion of mental and physical illness as judged by the degree of disability, and the medical and nursing attention required. The scale was: Mental Only (MO), Predominantly Mental (PM), Mental/Physical in equal proportions (MP), Predominantly Physical (PP), Physical Only (PO), Predominantly Social (PS).

Major misclassification was defined as "Mental Only" or "Predominantly Mental" in the geriatric units, "Physical Only" or "Predominantly Physical" in the psychiatric units, and "Predominantly Social" in either unit.

Condensed with permission from *Gerontologia Clinica*, 12(3):149–163, 1970.

### Misclassification (MO/PS Scale) and Hospital Units

*Females*—In females the degree of overlap between mental and physical illness of all degrees of severity is striking, less than half the cases being "Pure." In the psychiatric service one woman was totally misclassified physically (PP) and a further four had a significant physical contribution to a psychiatric illness (MP) while in all 22 had some physical component. Social factors were uppermost in two. In the geriatric service nine women were totally misclassified (MO, PM), a further nine had a significant mental loading (MP), while all 18 had some mental component to their illness. Social factors were uppermost in two.

*Males*—In males no gross misclassification occurred in the psychiatric service but four out of five patients had a physical component to their illness. In the geriatric service five men were misclassified (PM/MO) while one had a significant mental loading making six in all with mental illness. Predominantly social reasons for admission were present in one. In men the degree of overlap between mental and physical illness is striking, only 11 cases being "Pure." The small number of men under the care of the psychiatric service is surprising but supports the clinical impression that women form the psychiatric problem group in the elderly.

### Misclassification and Diagnosis

Using the extremities of the MO/PS scale (i.e., excluding the central MP) the misclassified patients can be grouped according to Mental/No

Mental diagnosis and Physical/No Physical diagnosis and then further grouped as misclassified or correctly classified.

*Females*—The presence of a double (Mental/Physical) diagnosis does not necessarily imply misclassification. One component of the illness may be of secondary importance and the correct classification easily seen. Alternatively, the absence of a double diagnosis does not imply correct classification. Grouping the cases according to diagnosis and misclassification, in females misclassification does not occur in the absence of a mental diagnosis and is seen chiefly in the geriatric service. Nevertheless, the majority of those with a mental diagnosis are in mental hospitals. This trend, although differing from the pattern shown when physical illness itself is related to misclassification, does not quite reach acceptable levels of statistical significance.

There is no trend toward physical illness in itself showing a contribution to misclassification. The seven cases with physical illness regarded as misclassified by geriatricians were so viewed by reason of additional mental illness. In the geriatric service, 75 percent of all cases with a mental diagnosis suffered from an organic psychosis of one form or another, and only the remaining 25 percent suffered from primarily affective illnesses.

**Misclassification and Age**

*Females*—Women under the care of the geriatric service tended to be older than those in the psychiatric service. When the age structure of the women in each service was compared with the population from which they were drawn, a highly significant excess of those over 80 years in the geriatric service was not repeated in the psychiatric service where the age distribution followed that of the total population. These differences seemed to be due to the merging of two separate distributions in psychiatric patients; the depressives and paraphrenics predominantly under 80 and those with organic psychosis who extend into the over 80 age group. Misclassification was not related to age.

*Males*—The two hospital samples again matched for age, but the geriatric group did not in this case differ from the population of Exeter with respect to age although a nonsignificant trend toward an excess of elderly patients was apparent. Misclassification was not related to age.

**Misclassification and Civil State**

*Females*—The female geriatric and psychiatric samples were comparable in civil state which did not contribute to misclassification. By far the largest single group were widows (55 cases) while, of the remainder, 19 cases were married and 12 were single.

*Males*—The two male samples were comparable for civil state which again did not contribute to misclassification. Sixteen widowers formed the largest single group while of the remainder, 10 were married and 3 single.

The main purpose of classification in medicine is to achieve accurate diagnosis and rational treatment (including aftercare). Classifications arise in the minds of doctors and are not ready-made by patients—but they are necessary in this case by the division of the hospital services for the elderly and by the view, not universally held, that mental illness is the exclusive domain of the psychiatrist and physical illness that of the physician. This approach also extends to nurses. Those trained in psychiatry

are best equipped to handle disturbed patients but may become overanxious in the presence of physical illness. Thus if co-existent mental and physical illness is a common feature of acute illness in the elderly the happiest results may stem from joint psychiatric and geriatric medical and nursing care. Lack of this joint approach may account for the high mortality in elderly patients admitted to mental hospitals.

Most geriatricians and psychiatrists feel that long-stay hospital accommodation should have the atmosphere of a home (but with hospital facilities). Patients who have reached this stage are likely to be resident for the rest of their lives. Because of the mixed nature of some illnesses joint supervision may be necessary, but the wards should be classified according to the social behavior of their patients rather than by diagnosis. Disturbed patients are distressing company for the immobilized or undisturbed and should be separated from them.

If the situation were rectified by the appropriate interhospital transfer of misclassified patients the trend would be toward further burdening an already over-burdened psychiatric hospital. The psychiatric hospital might well ask in compensation for more geriatric help with the physically ill patients in its admission wards.

Regarding the long-stay patients, this study suggests the need for the continuation of some, though perhaps less intensive, joint care. Since the problem group is composed of patients with organic psychosis and associated physical illness (mostly women) it is likely that at least some of the physical illness will become chronic. Delirious patients will have been excluded by the passage of time and the mental component will be dementia and by definition irreversible. At the moment this state of affairs can only be implied from the nature of the acute cases. The precise extent of the problem in the long-stay wards can only be determined by a study based therein.

What of the total picture? The high misclassification rate for organic psychosis suggests pressure from the community for the admission of such patients to any bed that is available. All institutions for the aged are subject to pressures from clinical and social "epidemics" (influenza, or the migration of younger generations). Unless the best use is made of resources and the proportion of beds for the elderly regulated according to the population at risk and the needs of other psychiatric patients, the number of aged patients in psychiatric hospitals will grow at the expense of standards in both this and other psychiatric fields.

Rather than create tension between the geriatric and psychiatric sections of the hospital service, it may be wiser to set up a joint service for long stay as well as acute cases, irrespective of the nature of the illness, and concentrate on active treatment where this is productive, and upon the efficient deployment of supportive resources. In practice both psychiatric hospitals and geriatric wards have to face the proper care of patients with multiple diagnosis. Instead of preoccupation with the misclassification of illness we should be more concerned with the comprehensive care of patients. In order to achieve the ultimate aim of service to the community the current arrangements would be improved by both administrative recognition and acceptance of the dual burden in each type of hospital, and by wider training of the medical and nursing staff concerned.

# The Geriatric House of Death: Hiding the Dying Elder in a Mental Hospital

ELIZABETH MARKSON

Francis Bacon said, "Men fear death as children fear to go in the dark; and as that natural fear in children is increased with tales, so in the other." Perhaps this is one reason why so little attention has been paid to the conditions under which men die. Much of this fear is valuable for survival, but fear has tended to obscure the conditions under which people die.

Older patients who enter State mental hospitals have an excessive death rate. A much larger proportion of people die than would be expected in comparison with age-sex specific death rates for the U.S. population. It has been suggested that this situation prevails because they are already dying when they are sent there. The prodromal signs of death are mistaken for psychosis.

In an attempt to decide whether those who send geriatric patients to State hospitals know that they are at an excessive risk of dying, the physical conditions of a group of 174 elderly patients admitted to one State hospital during an 8-month period were examined. One hundred and five women, aged 64 to 99, and 69 men, aged 65 to 104, comprised the sample. This hospital admitted all patients who applied.

The results show that elderly people with a multiplicity of serious physical illnesses, primarily heart and circulatory diseases, were being sent to the mental hospital. Indeed, 44 of the 174 died within 30 days after admission. The old people were not only physically ill, but their level of physical functioning was grossly impaired. Less than one-half were able to walk without assistance, 25 percent were "feeble," 11 percent were in a wheelchair, and 19 percent were on a stretcher, including 6 percent who were comatose. Those patients who were mobile were less likely to die than those who were feeble or worse.

It seems evident that moribund patients were being sent to a hospital specializing in the mentally ill. Did the people who sent them not know that they were dying? It is possible that these patients were referred to psychiatric care because their behavior mimicked mental illness. To test this hypothesis, the reasons recorded by the admitting psychiatrist for the referral of this group of patients were examined carefully.

Most of the old people were referred because of either senile behavior alone or in combination with such major psychiatric symptoms as delusions, hallucinations, or depression—whether they died or survived. The behavioral symptoms observed by the admitting psychiatrist did not distinguish those dying within the first month from those surviving except that six of the eight comatose men and one of those women whom the psychiatrist was unable to examine died shortly after admission.

No prodromal sign of death that could be distinguished from a psychiatric illness was detected among this group of old people even in psychiatric examination. This is particularly interesting in view of findings that personality changes occur among old people several months prior to death. It is possible that the psychiatric

Condensed with permission from *Aging and Human Development*, 1(1):37–49, 1970.

examination was so cursory that prodromal signs of death were missed, perhaps because the examining psychiatrists were aware that psychiatric treatment of the aged was secondary to providing a place to die.

It can be argued that a sick, confused person is easy to mistake for a mentally ill person, but it is significant that young patients are never sent to State hospitals in moribund conditions. Young patients on stretchers, in comas, or with intravenous tubes running are unlikely to be found applying for admission to this State hospital, and yet such patients exist and at times display toxic confusions similar to those of their elders. The older rather than the younger patient is selected for transfer to the State hospital because he is considered hopeless by family and physicians, because of the extreme pressure for hospital beds, and because he has compounded the low status of old age with illness and, often, poverty.

While the pressure to free general hospital beds for younger, less "terminal" or "hopeless" patients is a factor in the admission of old people to this hospital, the impetus to define them as mentally ill began with their families for about three-fourths of this group. Elders usually were designated first as either mentally or physically ill, a "diagnosis" made by their families and/or other members of the community. The patient was either sent directly to the State hospital, or taken first to a medical hospital or nursing home for treatment, depending on available facilities and the attitudes of those in closest contact with him.

What is surprising is that men whose families have pressed for their admission are more likely to die within a month than men referred only by formal agents, such as a nursing home or general hospital, or those referred by both families and such formal agents. This is not true for both sexes. It has been suggested that, if an old person wants to stay out of an institution, he should stay away from his friends and family. This would seem especially true for the dying man. Having outlived his usefulness, no longer productive, and becoming feeble or mentally confused, he is a strain on his wife, old herself, and/or his children who must care for him. He is "disposable."

Having one or more children tends to insulate old people against illness and relatively early death. Being a parent might also be expected to protect the aged from commitment to a mental hospital for terminal care. Paradoxically, while 40 percent of the men and 30 percent of the women admitted to this hospital had no living children, having children or the number of children made no difference to the risk of dying within a month after admission for the group, perhaps because once the family has decided to send the patient to a hospital their contact with him is reduced by distance. Any power the children had to postpone their aging parent's death is dissipated. The patient is socially dead and only his physical dying remains to be accomplished.

What role did bed pressure play in the admission of these elderly people? The majority who came from a hospital were sent from home to a receiving hospital because of behavioral problems or to a medical ward of a general hospital because of physical illness. While receiving hospitals have been the traditional route into State mental hospitals, they are overcrowded, and there is pressure to make quick disposition of patients without concern for the refinements of the

individual patient's situation. This may be particularly true for the elderly whose physical condition is largely ignored when a disposition is made.

The dying patients from the medical wards of a general hospital, like those from receiving hospitals, appear to have been sent because they failed either to respond to treatment or to die within a short period of time after being put on terminal care.

General hospital personnel are not fond of caring for geriatric patients. There are, however, institutions such as nursing homes which specialize in care of the terminal patient. Only a small number of old people were sent to the State hospital from nursing homes, and usually they were referred because they had presented some kind of disruptive behavior.

Unlike the general hospital, the nursing home does not seem concerned with freeing up beds occupied by old people nor with the threat of death. Rather, the nursing home is concerned with deviance, that is, with any threat to orderly and routine dying. Nursing home patients who survived longer than a month were sent because they also threatened orderly dying procedures; for example, one paraplegic cancer patient was referred because she had attempted to set fire to her bed, rather than to wait for death calmly.

This State hospital functions as a geriatric house of death to which the elderly are relegated because of the despair of families and the pressure on general hospital beds. There seem to be three elements that make up the pattern of withdrawal of interest and abandonment of the aged to a State hospital. One of these is old age, as viewed by our society. The old are already socially dying through relinquishment of roles and shrinkage of their future.

The second element is the heightened probability of dying associated with being old. Heightened probability of dying does not automatically lead to placement in a State hospital, for young patients who have terminal illnesses are more likely to be sent home for short periods of time and to return to die in the hospital.

The third element is low social status and lack of power. When old age and relatively low socioeconomic status are merged, the person is doubly worthless, for he is neither productive nor has he earned a reputation for his past productivity. A combination of being old, powerless, and terminally ill makes one an anathema to medical and lay people alike. Unless death comes on schedule, the triply-blighted individual is transferred to a State hospital. Here the old are hidden away, removed socially and spatially from their familiar surroundings while they await death.

The old dying patient, defined conveniently as "mentally ill" because he is unconscious, confused, or just plain ornery and above all else, old, deserves better than a hiding place to die. If we avow as a society that all human life is of value, why do we fail to discriminate between the old mentally sick and the old dying person?

# Crisis Intervention With Geriatric Hospitalized Patients

IRENE MORTENSON BURNSIDE

Are nurses doing crisis intervention with the aged? There seems to be little in the nursing literature geared to crisis intervention with the aged, particularly the aged who are confined to long-term facilities and are facing their own "desert places" alone. I would like to discuss how a nurse might implement a plan for crisis intervention with the aged, hospitalized patient who may also have impaired physical health. The need for immediate intervention into crisis and stress situations with the hospitalized aged arose when I was conducting weekly group sessions with seven geriatric patients in a convalescent hospital. These patients had been hospitalized for a minimum of 3 years.

As I studied the reasons for absences from the meetings, I realized that a patient usually missed the meetings because he was experiencing some unusual stress. It was then that I analyzed my interventions. At the time, I thought I was dealing only with the absence itself, and, fulfilling my role as the group leader, I had attempted to maintain continuity during the patients' vicissitudes. But, in retrospect, this was only a part of what I had done. I had intervened in the stress situations of my patients following:

A pulmonary embolus; the patient began to hallucinate, became confused, and disoriented.

A broken hip of a woman who learned of her sister's death 2 weeks later.

The death of a roommate of a blind man; shortly thereafter, the blind man was sent to a different hospital for X-rays and a bronchoscopy to rule out carcinoma.

The death of one of our group during the Christmas holidays.

A patient's transfer to a less desirable room (her third room transfer during the 10 months she had been in our group). She had enjoyed her room and was furious about the transfer; she wanted to leave the convalescent hospital immediately.

A bad fire in the room of one member. That same week, the man's roommate (whom he had tenderly cared for) died.

In these stress situations, the frequency of the word "death" was apparent. The theme of loss, of course, was also apparent. Assisting these patients in their grief, work was done in group meetings as well as in the individual meetings I had with these patients at their bedsides.

My interventions were based on short-term psychotherapy theory through sympathetic listening to the patient's story, communicating understanding, communicating confidence in one's approach, reassuring the patient he is not hopeless, and structuring the therapeutic situation.

My experience is that it is not difficult to establish a working relationship with the aged, unless the individual is very withdrawn. They are appreciative of someone to talk to and pleased to have someone listen to them. Also, aged persons are quite direct, and there is not much skirting of the issues that are troubling them. The problems come to the fore very rapidly if they are encouraged to speak to an attentive listener.

It was necessary to structure the situation for several reasons: (1) It had seemed to me that older people respond well to a certain amount of uniformity and routine in their daily living. (2) To allay some of my own

Condensed with permission from the *Journal of Psychiatric Nursing and Mental Health Services*, 8(2):17–20, 1970.

anxiety. (3) I had a limited amount of time to be effective, since I did all of this on a volunteer basis.

There were several things that I consistently found myself doing. I touched the patients frequently to bridge their isolation. I tried to be close to them physically, not only because of their isolation, but because they often could not see or hear well. I sat on their beds if necessary. Often I leaned close over the bed rails so they could see my face and hear my voice. I always called them by Mr. and Mrs., and did not use first names or "Auntie," "Gramps," etc. I did use their names frequently as a means of acknowledgment, whether there was understanding or not. I shared coffee and sweets with them.

The following guide spells out the strategy I evolved for crisis intervention with aged, hospitalized patients in stress or crisis situations.

I. Set up the terms of the contract with the patient.

Explain to the staff what you are attempting to do.

Consistency of visits important; length of time with patient gauged by patient's coping ability at that time.

II. Meet the patient in surroundings familiar to him. Environment should be reasonably quiet because of hearing problems or the confusion extraneous noises can create.

III. If patient does not bring up problem or reason for stress immediately, therapist can:

Listen.

Clarify that which you do not understand.

Intervene immediately in hallucination, delusions, and confusion. I have found that in these situations patients get confused about date and time, so I make a point of telling them what day it is, what month, what time of day, etc.

Consistently test reality. State how you see the present predicament, and how you feel about it.

Offer understanding, but do not give false reassurance. Do not give the impression that all is hopeless.

Not much hope is left for many of them, and it is too easy to assume their attitude instead of maintaining one's own viewpoint.

Explain what your limits are, exactly what you can or cannot do. Patients often wanted me to call relatives to come and get them, or for me to push them out the door, or take them somewhere else, etc.

Assist them with grief work:

Readjustment to the new environment
New relationships

To accomplish above goals, offer catharsis, support, and sympathy.

Share sweets or liquids with them. Coffee, beer, or tea were much appreciated.

IV. See the patient for only as long as he has difficulty in coping; do not foster overdependence on therapist.

V. Bring closure by reassuring the patient that he seems improved and that he has done well.

I hope that some of these strategies will be applicable to nurses elsewhere when faced with similar problems in their aging clientele.

# Community Mental Health Centers

RICHARD ELWELL

This article discusses some of the significant aspects of comprehensive community mental health programs and raises questions about nursing involvement and participation.

A primary objective of any mental health program is to distribute resources equitably for the maintenance and promotion of mental health as well as for the treatment and rehabilitation of the mentally ill and emotionally disabled.

The elements of a community mental health program or even of a community mental health center do not need to be under one roof to qualify for Federal funding. A comprehensive community mental health program requires the coordinated utilization of many health, social, educational, economic, and recreational agencies. A single system of mental health service must encompass facilities, including mental health centers and State psychiatric hospitals, agencies, and individuals under public and private sponsorship.

The need for mental health services in cities, towns, and rural areas has always exceeded their availability. The community mental health center program is the latest attempt to promote local-State-Federal collaboration in making such services available to greater numbers of people.

The implementation of the concepts basic to community mental health centers transcends the provision of clinical services and challenges the artificial separation of "hospital models" or "medical models" from "public health models." The force of change in these concepts should have impact on administrative systems, professional education, traditional roles of caregivers and consultants, and treatment sites. Psychiatric nursing practices and nursing education will not be impervious to the impact of these changes.

The term "community mental health center" has been used by a variety of facilities, and the services have ranged from truly comprehensive mental health programs to social clubs for former State hospital patients. Generally, the term has been used to describe a slighty enriched or expanded outpatient treatment clinic. But to be eligible for a Federal construction or staffing grant, a "mental health center" must meet a number of requirements including the five essential elements: Inpatient services; partial hospitalization; outpatient services; emergency services; consultation and education. In addition, five components of service are suggested: diagnostic services, rehabilitative services, precare and aftercare services, training, research and evaluation. In practice these usually are interwoven with basic services. Other requirements are that the services must be available to all residents of the catchment or service area. Some of the concepts in these requirements include three characteristics: continuity, comprehensiveness, and coalition.

### Continuity of Care

In one sense, a community mental health center is an administrative mechanism to promote delivery of services. The services in some settings do not differ markedly from those before the center organization was

Condensed with permission from the *American Journal of Nursing*, 70(5):1014–1018, 1970.

adopted. Usually, however, the administrative structure is an instrument for change. Continuity of care is enhanced by organizing or restructuring administrative relationships to facilitate the delivery of services.

Continuity may be provided by having one individual or one treatment team assigned responsibility for the patient from his entry into the system until the termination of his need for services. In a number of instances, continuity may be preserved through a series of interrelated agencies with a number of different providers of service.

An important corollary is the shift of focus from the prerogatives and interests of care-givers and facilities to concentration on the patient's needs. Treatment takes on a broader connotation than the staffs of clinics and hospitals generally employ. In nursing, perhaps the time has come to rescrutinize the differences between psychiatric nursing and mental health nursing, and between consultation and direct service.

Many mechanisms are being employed to prevent gaps in continuity, dropouts, or duplication of services. The regulations for Federal funding require that any person eligible for service within one element will be eligible for treatment within any other element of service, that any patient within one element may be transferred without delay to any other element provided that adequate space is available, and that information obtained within a given element will be made available to those responsible for the patient's treatment in any other element. Implementation of these regulations will require new roles for nurses in liaison, consultation, and information-sharing, as well as greater mobility and flexibility.

These requirements not only question traditional hoarding of information in the name of confidentiality, but aim at eliminating duplication of interviews and evaluations by professional personnel. Record-keeping procedures and forms may need to be revised, and recognition will need to be given to the fact that skill in interviewing and information gathering is not the prerogative of one or two professions.

One development has been the increasing utilization of "nonprofessionals" who, with on-the-job training, have assumed responsibility for manning emergency telephone services, directing help-seekers to care-givers, and performing essential information-gathering functions. Nurses, in developing effective working relationships with these new partners, need to guard against a tendency to consider every activity that nurses perform as an exclusively nursing function.

Other methods of promoting continuity include having personnel from one element of service follow patients to another facility. Or, having the staff of one element that receives patients for aftercare participate in treatment planning conferences in the sending facility. One development has been the increasing utilization of liaison personnel, often nurses, to maintain linkage from one component of the system to another.

A sample of 12 proposals to staff newly developed community mental health centers revealed implications for the preparation and assignment of nurses. Traditionally, the director of nursing services has selected nurses, practical nurses, and psychiatric aides for specific assignments. That is, specific individuals were assigned to inpatient wards and other individuals were assigned to work in day care or partial hospitalization services, in outpatient services, emergency rooms, etc. The survey revealed 35 out of a

total of 66 nurses were employed on this traditional basis.

The second pattern was for the nurse to follow her patients from inpatient to day care; 18 nurses held such positions. Two nurses were assigned to two other elements, one functioning in the outpatient service and on a home visiting team, and another in a position involving service in the outpatient clinic and in the psychiatric emergency service.

Six nurses were scheduled to operate in three elements of service. Of these the most frequent pattern was inpatient-partial hospitalization-home visiting team. Only one nurse was described as functioning in all of the component parts of the center. The shift from a single locus of service to a mobile position has implications far beyond preparing nurses to function in a variety of settings. It is striking that of the 66 new positions only three references were made to responsibility for consultation and liaison with public health nurses and with nurses employed by State hospitals and other agencies.

**Comprehensiveness**

Comprehensiveness is used in a number of ways to describe mental health services. "Comprehensive" implies not only a variety of different methods or sites for delivery of mental health services, but the use of a variety of direct and environmental or indirect techniques. Comprehensiveness means providing needed services for all the people in the area regardless of age, diagnosis, chronicity of condition, etc.

Comprehensiveness connotes a merger of several models of psychiatric treatment with the basic preventive functions of public health. The focus shifts from concern of the practitioner about the process of therapy to concern for the individual and his circumstances: family, home, school, community.

Truly comprehensive community mental health centers do not spring into bloom from a desert of nonservices through fertilization with Federal funds. It will take several years for a former child guidance clinic to reach the level of development that assures provision of appropriate services to all residents in the area.

It will take even longer for professional personnel to become comfortable with interventions that are aimed at assisting a person to achieve or maintain social competence. Social action programs and other preventive activities will need to be considered in the distribution of personnel resources if consultation is expanded from case consultation to agency consultation and on to program consultation.

**Coalition**

The requirements for Federal funds to construct a community mental health center or assist in staffing have fostered collaboration and affiliation among a number of facilities and agencies. The average center in its first year of operation has an operating budget of approximately one million dollars. Major sources of funding the 65 percent of the cost not covered by Federal funding have been estimated at 40 percent State and local funds; the remaining 25 percent consists of 5 percent cash, pledges, and gifts; 13 percent from patient's fees, and 7 percent from third-party payments.

The cost of staffing these new facilities is of primary concern. Insurance and other forms of third-party payments, as well as effective collaboration between local and State funding sources, will be essential if community

mental health programs are to survive.

Equally important will be the need to establish effective working relationships between a coalition of health, social, and educational agencies and facilities. Only 26 percent of the centers funded to date are sponsored by a single agency.

Sponsors include public agencies (county governments, municipalities and States) and private, nonprofit facilities. Within these groupings, public and voluntary nonprofit general hospitals made up 73 percent; out-patient clinics, 5 percent; and special purpose corporations, including mental health centers, mental hospitals, local government units, and charitable organizations, the remainder.

Effective collaboration of a number of participants in a community mental health program from a variety of public and voluntary nonprofit organizations will require the personal and professional investment of a number of individuals and significant involvement of nurses.

One major problem may be the number of conceptual frameworks represented by the partners in this coalition. A comprehensive system involves not only treatment and rehabilitation personnel, but educational, vocational, social welfare, and community organization specialists.

Nurses seeking positions in community mental health programs would be well advised to explore the organizational framework and operating philosophy of the center, as well as the relationship of nursing services to other components of service and the stated and implied expectations of nurses.

Some guidelines that might be used to assess the comprehensiveness, provisions for continuity of service, and extent of coalition of a mental health center include:

Capacity to provide services for many people from a variety of social, economic, and age groups with conditions ranging from the need for emergency interventional shelter to long-term intermittent support.

Extent of involvement and utilization of other existing services and facilities, community-based professionals, and allied groups.

Scope and rationale of treatment methods employed.

Utilization of new categories of staff and traditional personnel in new roles.

System for communicating and coordinating services within the center and with affiliating agencies and community groups.

Expectations of the nurse by others as a care-giver, treatment agency, consultant, coordinator, organizer, and teacher.

Amount of mobility and flexibility in the assignment and its relationship to the total treatment milieu.

# Toward a Theory of "Behavioral Prophylaxis"

ERNEST G. POSER

The idea of primary prevention, though long accepted in public health, has only seriously entered the thinking of psychiatrists in the past few years. It will be the burden of this paper to suggest an approach to prevention based on principles of learning.

It is a fundamental tenet of clinically oriented learning theorists that many maladaptive responses result from faulty conditioning or the failure of adaptive conditioning to occur. The introverted neuroses such as anxiety and obsessive reactions are examples of the former, while enuresis and some forms of antisocial behavior are examples of failure of conditioning. If this model is able to generate concepts useful in the reversal of maladaptive behavior, it seems inviting to apply these same concepts to the prevention of such behavior.

One assumption is that the state of normality, or freedom from symptoms, is partly ascribable to the spontaneous occurrence of certain life experiences capable of conferring immunity to some forms of behavior deviation. Conversely, lack of exposure to such experiences may create a behavioral *locus minoris resistentiae* and thereby increase the likelihood of future breakdown.

The separation anxiety or "homesickness" observed in nursery school pupils, or children attending summer camps, is an example. Such separations are frequently associated with crying, despondency, loneliness, inactivity, and anorexia. Clinical observations suggest that these maladaptive responses occur mainly in those in whom the transition from home to school or to camp has been too abrupt. No doubt children vary in the degree of separation stress they can tolerate, but they likewise vary in the amount of exposure they have had to similar, but less intense or protracted, experience.

Could it be that a form of "antecedent systematic desensitization," in which increasing degrees of separation are gradually introduced both in fantasy and real life, serves to reduce the incidence of separation anxiety? One might ask whether audience or stage fright might be prevented by similar techniques; or whether fear of death, so often associated with obsessive reactions, could be prevented in susceptible individuals by providing them with graded preexposure to stimuli relevant to death. The use of predelictual aversive conditioning for those prone to develop addictive behavior is yet another possibility once these individuals have been identified.

Evidence for the feasibility of these suggestions is sparse. What there is, arises from three areas of investigation. The first derives from the animal laboratory, the second from human laboratory investigations, and the third, from a clinical setting. None of these studies was designed to explore parameters of "behavioral prophylaxis," yet all can be exploited to that end. If the mechanisms involved in remedial learning techniques such as desensitization, flooding, and aversive conditioning, indeed "immunize" subjects against later encounters with traumatic events and their associated stimuli, a host of studies on stimulus preexposure or "latent inhibition" seems relevant.

---

Condensed with permission from the *Journal of Behavior Therapy and Experimental Psychiatry*, 1(1):39–43,1970.

The evidence from animal, human, and clinical studies lends support to the conclusion that stimulus specific prophylactic interventions do modify subsequent stress responses. Of particular significance is the fact that preexposure of the conditioned as well as the unconditioned stimulus inhibits the formation of conditioned avoidance responses. If it is true that some deviant behaviors such as phobias, obsessions, and addictions are a matter of maladaptive conditioning in some cases maintained by instrumental avoidance of the conditioned stimuli or by the reinforcing properties of noxious conditioned responses, then a number of promising research approaches to prevention present themselves.

Initially research might focus on populations in "high risk" life situations; for instance, overprotected children about to enter nursery school, high school students prone to audience anxiety, venturesome teenagers "exploring" sociopathic or addictive enterprises, pregnant women prior to their first experience of labor, and possibly dental or surgical patients expecting to undergo traumatic interventions.

The prophylactic methods could be as wide as the armamentarium of contemporary behavior modification. For some forms of prevention, desensitization, flooding, or covert sensitization may prove to be the methods of choice. For others modeling, aversion, or contingent reinforcement techniques could be more appropriate. Such methods differ from traditional preventive measures in that they aim to modify specific target behaviors the absence or presence of which should be demonstrable once the preventive measures have been applied.

By contrast to therapy research in which the withholding of treatment is often seen as an unjustifiable deprivation, "untreated" control groups for the evaluation of preventive measures should be relatively easy to obtain. Hence if any particular preventive technique is found empirically to be unproductive, it can quickly be modified or replaced. This has not been possible for many techniques because their putative effects are not amenable to operational definition.

Because there is reason to believe that graded preexposure to a variety of stimulus situations may be an essential ingredient of normality, conditioning techniques commend themselves as prophylactic agents. It may turn out that primary prevention in the mental health field is better served by the deliberate exposure of susceptible individuals to learning experiences spontaneously encountered by most normal individuals than by providing them with sheltered or protective environments.

# A Super-Ego for Cross-Cultural Research

F. Kenneth Berrien

One of the chief instruments contributing to the expansion of cross-cultural studies has been the jet airplane. It has permitted more researchers to rub cultures together in ways, and with a frequency, never before possible. This shrinking of time has brought a number of ethical, professional, and technical issues which merit consideration. Let me approach these issues by offering a list of ideal conditions for cross-cultural research and some considerations that make it difficult to attain them.

The best cross-cultural research is that which engages the *collaborative* efforts of two or more investigators of *different* countries, each of whom is strongly encouraged and *supported* by institutions in their respective countries to address *researchable* problems of a common concern not only to the science of psychology but relevant to the *social problems* of our times. Such collaborative enterprises would begin with the joint definition of the problems, employ comparable methods, pool data that would be "owned" by the collaborators jointly who are free to report their own interpretations to their own constituents but are obligated to strive for interpretations acceptable to a world community of scholars.

Collaborative efforts of two or more investigators of different countries needs little emphasis. However, to avoid the scientific and ethical objections in what has been called safari research, I would argue that the best comparative social research is done when researchers are identified with the cultures under study. To meet this "ideal condition" limits the cultures we may compare to those relatively developed. This restriction is no reflection on those who have worked without indigenous colleagues in remote areas. Such studies are necessary first approximations upon which psychologically enriched investigations can be built under more favorable conditions.

Let me now turn to the necessity for a sympathetic and encouraging institutional climate. Not all investigators interested in cross-cultural research hold positions in organizations characterized by an international outlook. For some, a provincial view is understandable. Others have been bruised by experiences such as the Camelot project, and have adopted de facto policies which inhibit, discourage, or prohibit their staff from engaging in direct collaborative arrangements abroad. It is impossible to consider intercultural research unless the institutional context is favorable. We are not free agents to pursue our quest for new knowledge, the academic mythology notwithstanding. It is regrettable that some universities, private foundations, and governmental agencies have taken on an isolationist tinge at a time when commercial, tourist, and political intercourse is rising exponentially and the need for fundamental cross-cultural data is greater than ever. We may be effective in developing the appropriate institutional climates if we engage in more than exhortation. And here I want to confront the third and fourth conditions for effective cross-cultural research.

We can limit ourselves to fundamental basic problems which are politically neutral or irrelevant. Most of

Condensed with permission from the *International Journal of Psychology*, 5(1): 33–39, 1970.

what has been done cross-culturally has been of this character.

I have an uneasy feeling about such an easy conclusion. It amounts to a scientific isolation, a monastic subculture in which we pose our own questions, deriving answers understandable to ourselves but unintelligible to those not in the scientific priesthood. At least in the United States, one can detect the feeling that behavioral scientists could make greater contributions to the problems of our urban crunch, clogged transportation, fouled environments, deprived minorities, and the youth rebellion. While these are domestic problems they are no respecters of national boundaries. Student revolts appeared in Latin America and Europe before they became common in the United States. The migration to the cities is crowding Rio as well as New York, Santiago as well as San Diego. We must recognize that support for behavioral research comes ever more from tax sources. Are there not moral or ethical obligations attached to such support? Unless behavioral scientists can translate their research into language relevant to the current human condition we may lose in respect and more in the way of support.

I would urge two precautions: We cannot afford to thrust our wares into places and problems without invitation. As a profession we have not yet been accepted as nonpartisans with the impersonal detachment toward our subject matter which characterizes physicists or economists, astronomers or geneticists. Some of the resistance stems from the belief, often disguised, that we may uncover conditions embarrassing to some controlling segment of society, and simultaneously become advocates either of social change for a reactionary status quo. We can only be useful as we demonstrate a capacity to examine and compare psychological processes at work in a variety of social systems, running the risk of calling attention to conditions which could or should be modified, but avoiding the role of advocate as long as we wear the hat of a researcher.

The fifth condition is the joint definition of research problems by two or more collaborators drawn from different cultural traditions. Let us assume that they have agreed to attack some broad area like political values of opinion leaders, or the decision-making procedures of community organizations, for the purpose of comparing one culture with another. The collaborators are in the predicament of dealing with some of the cultural differences in themselves that they hope to understand through their research. None of us transcends the marks of our own cultural biases. While the scientific method has a certain universality, its coloration differs across different universities even within a country, and across different countries.

The joint definition of the problem has a time dimension. Often one investigator develops an idea but before he feels confident enough to approach a collaborator he may run a pilot study. He then may look for some colleague in another country. Already the problem has taken a form which the initiator is reluctant to modify. Perhaps it is in the nature of things that such resolutions will be of this kind. But if we are sensitized to the issue the compromises may be less unbalanced.

It is axiomatic that comparable methods be employed if we are to have comparable data. This does not mean that in every detail the methods must be identical. Given differences in language, identity in methods is impossible. But beyond that, other

differences force some compromise with strict operationalism. For example, a study of Samoan and American values among community decision makers is complicated by the fact that the village chiefs in Samoa have no role counterparts in mainland communities. This means that some questions asked of a chief must be different in content from those asked of a councilman in the United States. The principle is that procedures designed to assess a construct in two or more cultural settings must be as similar as the cultural limitations (including language) permit, recognizing that a strict operational definition of the construct is impossible.

The principle that the data pool is the common property of the collaborators follows from the initial conditions of collaboration. However, in those cases where a foreign investigator has embarked on his safari with minimal aid of an indigenous informant and translator, he has been the sole owner of the data. Whatever data one may gather from a foreign area profit from the interpretive aid of someone acquainted with research methods and the culture. There can be no justification for returning home with a locked box of data "mined" from a distant culture without permitting indigenous people to share in the information drawn figuratively from beneath their noses.

It may appear that once the data are in and statistically analyzed to the satisfaction of both collaborators, their interpretation should provide no problems. The reverse is likely. The essence of science requires a critical examination of data against alternative hypotheses. Such alternatives are more evident when working with a foreign colleague who perceives the analyzed data as a figure in the cultural ground different from one's own ground. I know of one instance in which two collaborators, after prolonged and sincere efforts to agree on their final report, chose to write two reports, one for each country. It was not translation difficulties, nor disagreement over the data analysis itself, but rather the cultural relevance of the interpretations that finally forced the need for two publications.

Psychological and especially social psychological theory must break out of the bounds of the college sophomores, whose behavior, perceptions, and cognitions have been explored within the cultural and subcultural fences, especially of the western world. We have no culture-free dimensions of measurement comparable to time, mass, and distance of the natural sciences. The models of behavior developed by Latin Americans or North Americans bear the stamps of their origins and may not—probably are not—applicable to the peoples of Asia, Eastern Europe, or Africa. Only by extension of our efforts to cross-check hypotheses in other cultural settings on population samples more representative of humanity worldwide can we establish the fundamental principles of our science. In such an endeavor we may attain the impartial, nonpartisan stance that is the hallmark of a scientist contributing in some significant measure to improving the human condition.

what has been done cross-culturally has been of this character.

I have an uneasy feeling about such an easy conclusion. It amounts to a scientific isolation, a monastic subculture in which we pose our own questions, deriving answers understandable to ourselves but unintelligible to those not in the scientific priesthood. At least in the United States, one can detect the feeling that behavioral scientists could make greater contributions to the problems of our urban crunch, clogged transportation, fouled environments, deprived minorities, and the youth rebellion. While these are domestic problems they are no respecters of national boundaries. Student revolts appeared in Latin America and Europe before they became common in the United States. The migration to the cities is crowding Rio as well as New York, Santiago as well as San Diego. We must recognize that support for behavioral research comes ever more from tax sources. Are there not moral or ethical obligations attached to such support? Unless behavioral scientists can translate their research into language relevant to the current human condition we may lose in respect and more in the way of support.

I would urge two precautions: We cannot afford to thrust our wares into places and problems without invitation. As a profession we have not yet been accepted as nonpartisans with the impersonal detachment toward our subject matter which characterizes physicists or economists, astronomers or geneticists. Some of the resistance stems from the belief, often disguised, that we may uncover conditions embarrassing to some controlling segment of society, and simultaneously become advocates either of social change for a reactionary status quo. We can only be useful as we demonstrate a capacity to examine and compare psychological processes at work in a variety of social systems, running the risk of calling attention to conditions which could or should be modified, but avoiding the role of advocate as long as we wear the hat of a researcher.

The fifth condition is the joint definition of research problems by two or more collaborators drawn from different cultural traditions. Let us assume that they have agreed to attack some broad area like political values of opinion leaders, or the decision-making procedures of community organizations, for the purpose of comparing one culture with another. The collaborators are in the predicament of dealing with some of the cultural differences in themselves that they hope to understand through their research. None of us transcends the marks of our own cultural biases. While the scientific method has a certain universality, its coloration differs across different universities even within a country, and across different countries.

The joint definition of the problem has a time dimension. Often one investigator develops an idea but before he feels confident enough to approach a collaborator he may run a pilot study. He then may look for some colleague in another country. Already the problem has taken a form which the initiator is reluctant to modify. Perhaps it is in the nature of things that such resolutions will be of this kind. But if we are sensitized to the issue the compromises may be less unbalanced.

It is axiomatic that comparable methods be employed if we are to have comparable data. This does not mean that in every detail the methods must be identical. Given differences in language, identity in methods is impossible. But beyond that, other

differences force some compromise with strict operationalism. For example, a study of Samoan and American values among community decision makers is complicated by the fact that the village chiefs in Samoa have no role counterparts in mainland communities. This means that some questions asked of a chief must be different in content from those asked of a councilman in the United States. The principle is that procedures designed to assess a construct in two or more cultural settings must be as similar as the cultural limitations (including language) permit, recognizing that a strict operational definition of the construct is impossible.

The principle that the data pool is the common property of the collaborators follows from the initial conditions of collaboration. However, in those cases where a foreign investigator has embarked on his safari with minimal aid of an indigenous informant and translator, he has been the sole owner of the data. Whatever data one may gather from a foreign area profit from the interpretive aid of someone acquainted with research methods and the culture. There can be no justification for returning home with a locked box of data "mined" from a distant culture without permitting indigenous people to share in the information drawn figuratively from beneath their noses.

It may appear that once the data are in and statistically analyzed to the satisfaction of both collaborators, their interpretation should provide no problems. The reverse is likely. The essence of science requires a critical examination of data against alternative hypotheses. Such alternatives are more evident when working with a foreign colleague who perceives the analyzed data as a figure in the cultural ground different from one's own ground. I know of one instance in which two collaborators, after prolonged and sincere efforts to agree on their final report, chose to write two reports, one for each country. It was not translation difficulties, nor disagreement over the data analysis itself, but rather the cultural relevance of the interpretations that finally forced the need for two publications.

Psychological and especially social psychological theory must break out of the bounds of the college sophomores, whose behavior, perceptions, and cognitions have been explored within the cultural and subcultural fences, especially of the western world. We have no culture-free dimensions of measurement comparable to time, mass, and distance of the natural sciences. The models of behavior developed by Latin Americans or North Americans bear the stamps of their origins and may not—probably are not—applicable to the peoples of Asia, Eastern Europe, or Africa. Only by extension of our efforts to cross-check hypotheses in other cultural settings on population samples more representative of humanity worldwide can we establish the fundamental principles of our science. In such an endeavor we may attain the impartial, nonpartisan stance that is the hallmark of a scientist contributing in some significant measure to improving the human condition.

# The Simulation of Psychosis: A Contemporary Presentation

BRUCE RITSON and ALISTAIR FORREST

Our aim is to draw attention to a syndrome which we are seeing in this hospital with increasing frequency. We describe patients presenting with some of the phenomena of schizophrenia. In three cases there seemed little doubt that the patient had had a previous schizophrenia episode, but the episode with which we are concerned was simulated. It seemed that the illness did not represent a breakdown of ego organization, but a conversion symptom similar to the more familiar physical presentations of conversion hysteria. Now that our patients are becoming more sophisticated, they are learning to produce iconic signs of schizophrenia.

A.I.B. was born in 1951, the third of a family of five. Her father had died when she was 10; this was a traumatic loss. Her mother visited her and reported that A.I.B. was "the same as always." A nurse said she knew the family—they were all pretty odd. At the age of 11, A.I.B. became "interested in mental illness" and read all the books in the public library. She ran away from home five times and left school. She worked for a religious "fringe group," who offered help to the "drop-outs." In Oxford, she was on "pot" and decided to investigate the inside of a mental hospital. The consultation in May 1968 indicated that she was hallucinated and had ideas of persecution. She was admitted, and in June was transferred to Edinburgh. In our clinic she said that she had made it all up and was discharged. She was readmitted 2 days later having taken an overdose of vitamin pills. She reported that she was mad, but at a "contract interview" agreed to relinquish this role and accepted a work role in the geriatric wards.

M.F. was first seen by psychiatrists at the age of 12, when she had "school phobia." Her father was a manic-depressive of long standing. Her mother had had episodes of depression and died in 1967. M.F. had been under psychiatric care at 18, and at 21 years, when she had a 6 months' exposure to a therapeutic community. An intelligent girl, she had taken an interest in amateur dramatics and had trained as a receptionist. When she presented in 1968 it was with somatic complaints of a hypochondriacal nature. It was not possible to get her to discuss her real problems. Her mother's death had been a crisis which had precipitated her return to Edinburgh. She had seen one of her "old therapists" who had not acceded to her wish for readmission, but she achieved this by manipulation of the family doctor, and was seen as an emergency by one of us. She was admitted, had three ECTs and made a too dramatic recovery. When about to be discharged, she insisted that she was not ready and became psychotic again. She was discharged to a hostel, but was returned within 2 days because of disturbed behavior. On return to the hospital, she seemed to live in a world where her wishes had become reality, i.e., she did not like her new (disturbed) ward and convinced staff members that a bed had been arranged for her in the admission ward. When she returned to the admission ward she reverted to her hypochondriacal complaints.

A different problem for the hospital psychiatrist is that of the schizophrenic who has become dependent on the institution and plays "schizophrenic" when attempts are made to get him work or discharge him.

E.R. and D.C. were both recognized as having had paranoid schizophrenic illness, though both were symptom-free in the early summer of 1968. Repeated efforts to get them to work were refused. Each was given a discharge date, but E.R. made it clear that he knew "ways and means of getting back." We finally readmitted him because he was causing so much work to the police and casualty department. D.C. hung around the hospital corridors and would escort any staff members that he

---

Condensed with permission from the *British Journal of Medical Psychology*, 43 (1):31–37, 1970.

saw and explain to them that he was the "wickedest man in Edinburgh" and that his only wish was to get work. He was such a nuisance, albeit a trivial one, that we readmitted him also in the early autumn. Our preoccupation with discharge rates perhaps reflects our unconscious wish to comply with the expectations of the Ministry of Health and its advisers.

The next two patients seemed to us to present a different problem. M.M., aged 45, first came to this hospital in May 1968. She was sent as an emergency to the out-patient department and diagnosed an acute psychotic reaction. Next day she was seen by the registrar, who told her that she would have to stay some weeks. She "recovered" over 24 hours and asked to see the psychiatric social worker as there were monetary problems. Her history revealed a cyclical recurrence of financial and marital disaster. This admission was her sixth. She had also been in gaol for theft. At group meetings she was at first quiet and constructive, but when she was told that she would be discharged she reverted to "playing schizophrenic." She was discharged, and 2 weeks later a psychiatrist in another town asked if we would accept for admission M.M. who had been charged with striking a policeman on his helmet. We demurred, but the court had already ordered her admission under Section 55 of the Mental Health (Scotland) Act, 1960. This time she went to a "disturbed ward" and left after a few weeks. One of us was asked to see her in prison in September 1968. The charge was theft. Asked if she had any mental or nervous trouble, she said that she was feeling fine, and hoped to get off with a fine and soon rejoin her husband and children.

A. McG., aged 29, was first admitted in June 1967 when she claimed to be suffering from schizophrenia. She was the second of a family of four born to an illiterate and probably subnormal mother. The father deserted from the army, was "on the run" for a long time. He died in 1963. One sister is married to a housebreaker. For much of her childhood, A. McG. was "in care." She married at 20 and has had four children; one died at 7 months, and another is hydrocephalic. She has had several miscarriages, one procured by herself. Her husband is drunk every weekend and seldom works. When straits become desperate she goes on the streets. She has been in hospital three times since her first admission, complaining of hearing her doctor's voice and of being influenced by a machine which "made me do bad things." She complained also of being persecuted by the Nuns. Apart from admissions, she has been a day-patient for several months, and an out-patient intermittently.

In Charcot's time, hysterical patients presented with neurological symptoms. The concept of conversion hysteria as a disease entity has aroused controversy, but in this clinic hysteria in the guise of neurological disorder is rare. The form of illness (or message) chosen by the patient will be determined by the culture, but in addition the first discourse with the doctor will crystallize out the most acceptable mode.

The question arises: how can we be sure that the episodes were simulated? The psychiatric interviewer is a participant observer, experiencing the event but also observing the experience. In interviews with schizophrenic subjects, the psychiatrist often feels puzzled, sometimes anxious, and experiences the alienation of the subject. Some teachers have suggested that if the psychiatrist begins to wonder who is crazy, him or me, then the possibility of schizophrenia looms large. Another point is that most schizophrenics are not eager to discuss their experiences, and it requires skill to get the data on which to base a diagnosis. In the episodes described here the patients displayed their symptoms in a way more reminiscent of the overstatement of the hysteric.

We suggest that there were two classes of psychiatric patients: those in whom "the machine had broken down" and those who presented symptoms suggestive of such a breakdown. There is a third category encountered in private analytic practice: those patients who present with

problems in living. This raises the speculation that the clinic is propagating a model of what is "acceptable illness," at least for those who seek admission.

The diagnostic concepts of conversion hysteria and malingering seem irrelevant to the present-day function of the psychiatrist. To take conversion hysteria as a paradigm: the physician examines a patient who claims that his legs are paralyzed and reports that he can find no organic disease; the psychiatrist interviews him and reports that the paralysis is caused by an unconscious conflict. We approach the problem from a semantic standpoint and say this patient is talking in the language of bodily illness, let us see if we can persuade him to talk the language of relationships, feelings, and problems in living. This is by no means easy. We have been experimenting with a procedure which we call the "contract conference," which may facilitate such translating work.

Some of the patients reported on here attended a "contract conference." A.I.B. announced that she was mad, hearing voices, etc. We told her that is was unnecessary to play the "mad" game, and that we might be able to help her if we could discuss her real problems (i.e., problems in living). She said that she felt out of place at home and that she wanted a job that would make her "feel wanted"; we got a contract that gave her 4 weeks' work in the geriatric wards with a view to giving her a reference for a local nursing home. This contract was completed, though we think that after discharge she returned south.

The problem of the remitted schizophrenic who is thought to be "playing schizophrenic" is more complex. Some chronic schizophrenics talk "schizophrenese," especially if they are presented to students. Others avoid central problems of relationship by reverting to psychotic mechanisms. In one patient in our series (J.D.), an intelligent American postgraduate, who had completed a course in counseling, it was apparent (to her and to us) that she reverted to "talking daft" when she got "too close to people." The two other patients, whom we tried to discharge and who succeeded in gaining readmission, were, we think, consciously motivated but were perhaps correct in their appraisal of their assets and prospects in the world outside. They and we believe that the asylum function of mental hospitals is still a social necessity.

# The Decline of Individualism

NEVITT SANFORD

My focus here is on the decline of individualism in our society. How does today's society discourage individuals from becoming autonomous persons?

### Neglect of the Whole Person

Professional people focus on a person's particular symptom or problem without regard to the implications of their actions for other areas of functioning in that person. Professional structures are difficult to change, because each professional has a great deal of interest vested in his work and there is no one to direct attention to the whole person by organizing the specialities.

Paralleling what is happening in practice is the trend in science toward division of scientific activities into specialized inquiry. We see this in the way the search for knowledge is organized and in the current trends in theory making itself. The abandonment of the concept of soul helped to pave the way for the psychological fragmentation of the person and the growth of professional impersonality goes along with fragmentation in psychological science. For a time it seemed that the concept of personality would serve to refer to the wholeness and the uniqueness of the person, but in departments of psychology, "personality" has come to be regarded as almost as "spooky" as the concept of soul.

*Psychoanalysis*—In the late 1940's, young people and students were asking "Where can I find an inexpensive analyst?" Interest in analysis has almost disappeared, and this makes an interesting but rather disturbing story. Psychoanalysts are writing papers that are comparable, often unfavorably, with some written in the twenties. They have neglected psychological research. They have tied themselves to medicine and lost what could have been gained by alliance with the humanistic spirit in universities (or which used to be in universities). Psychoanalytically oriented psychiatrists and psychologists tend to focus on the particular symptom or dysfunction without paying any more attention to the whole person than do other practitioners.

I have been teaching at Stanford —teaching, of course, in personality. The dominant interest in research and teaching is related to learning theory, and the psychology of personality is struggling to survive. Almost all students have been so well versed in learning theory that the quarter is almost over before I can sense that they are "tuning in" on what I am trying to talk about. Each year a few students want to read in the literature of psychoanalysis—classical and revisionist. Most are Catholics transferred from eastern Catholic institutions. Whereas the majority of students go along with behavioristic psychology and what it implies, Catholic students are sufficiently familiar with inner conflict so that psychoanalysis is meaningful. I imagine that Catholic institutions may be one place in which Freudian ideas are kept alive, until curiosity about people drives academic psychologists once again to take these ideas seriously.

Some signs of a counter trend are apparent. Analytic theories are being presented in departments other than psychology. Historians, for example,

---

Condensed with permission from *Public Health Reports,* 85(3):213–219, 1970.

are interested in psychoanalytic or personality theories as an approach to understanding history. Similarly, they are taught in departments of political science. We could suggest to students that if they want to study personality they would be better off in a department such as political science, where some people are discussing personality.

*Changes in science*—If a person is fragmented in our theories about people, then naturally this may become the basis for fragmented practice. Or, if in theory the person disappears into a collective process or into a social structure, practice is likely to be designed to affect those structures and processes without attention to the individual. How has science come to view things in this fashion? Science has been influenced by the same social and historical processes which have influenced professional practice. The individual is disappearing in the sense that it is becoming increasingly difficult for a person to act as an individual.

This is as true of the university as of other organizations. It has to do with the fact that the models of business and industry and the military have been adopted by the university itself. There is a triumph of efficiency and rationality which is difficult to change because this is the way individual careers are defined. Administrators of universities, like administrators everywhere, are caught in the demands of their roles and are rarely able to make a personal imprint on their job.

I need only mention the textbook business. Recently, I read a revised textbook in psychology. The accent in the chapter on personality and behavior change is on behavior therapy and cognitive dissonance. I know that the author is not a devotee of behavior therapy or cognitive dissonance; he accented these topics because a market survey suggested that this is what teachers are interested in. This is an example of how larger social processes may determine what should be the most individualistic intellectual work of a scholar.

*Demands of production and consumption*—According to Marx, people are shaped by the demands of productive operations. For example, we segregate children by age, sex, intelligence, and personality in classrooms. All children in each group are presumably alike, allowing a kind of efficiency in teaching and in organization of work. We define roles more and more precisely and insist that individuals do just what those roles require. Never mind whether the work gives a person a chance to express himself.

The same thing is happening in consumption. Ways of consuming are guided in the interest of the market and of keeping the corporation going. There is little need for an individual to decide what he will consume because this is made clear in advertising and movies. These ways of consuming are sufficiently gratifying so that we go along with them. This process is damaging to the individual. He is freed from making decisions and he is momentarily satisfied, but I believe his gratification is not fundamental.

Even our sex lives are open to this regulation and administration. It started with the "Kinsey Report" when everyone could be guided by the knowledge of what everyone else did and what was approved in our society.

### New Social Phenomena

Against this background, I wish to discuss the new social phenomena—devaluation of privacy, new sexuality, new "encounter" groups, and new

anti-intellectualism. These phenomena have to be understood as partly a reaction against the domination of our lives by technology, but at the same time as identification with technology. Maybe these phenomena would not be possible if people knew about or believed in an adequate psychology of the person.

*Devaluation of privacy*—Privacy, and to some extent, solitude, is vital for the development of personality. It is a way to establish the boundaries between one's self and the rest of the world. Privacy or solitude is essential to sustain the individual against the society. But technological society pays no attention to privacy. There are numerous files on each of us; they start accumulating in elementary school. Anyone can obtain copies of tests taken in school, and numerous people have access to such tests. Another example is credit ratings—one can get a credit rating on almost anyone, a rating based on interviews with his neighbors and on a study of the garbage pails from his house.

We are exposed to all kinds of intrusion and this is a basis for all kinds of external control. It is peculiar that today's avant-garde is insistent on "total honesty" and "openness." It is almost as if there were an identification with those processes which downgrade the concept of privacy. I can understand the revolt against the "system" which is seen as a source of alienation and loneliness and, therefore, an accent on getting together with other "alienated" people and being open with them. But have they considered the complexity of what is involved? Of course, a person is a social being, but it makes a difference how the social relations are mediated in the person.

It is destructive to be merged with a group and unable to think of one's self as apart from the group. The Nazis used the device of making people think of themselves as members of groups as a way to destroy individual personality. It is different to achieve a genuine intimacy with other people based upon a structure of personality in one's self and an appreciation of the complexity of the other person. This kind of intimacy takes time. It cannot be done right away, as seems to be assumed by many approaches to therapy and group relations today.

*The new sexuality*—The sexuality I am talking about is the apparent liberality of highly educated and affluent people. I refer to wife-swapping and tolerance of what can be shown in the movies and on newsstands. This has become part of our culture. Its ideology is set forth in popular magazines. It is in keeping with all kinds of commercial interests.

Is this really sexuality? It is not one's own sexuality. It is a set of practices taken out of the context in which such practices belong. It is mere behavior, the meaning of which is not determined by one's self, not determined by its place in a complex set of processes going on in the person, but by external determinants of this particular behavior pattern.

How can educated and intelligent people participate in such activities? I can understand how a person who has been brought up puritanically sees the personality as made up of two things—puritanical standards and pure impulse. If such persons are determined to get rid of their puritanical standards, they turn to expressing their impulses as freely as possible. They fail to see sexual behavior as integral with the personality or to understand that satisfaction is attained from sexual behavior when it is a means for expressing a variety of complicated feelings and motives.

The same holds true for drug abuse —the notion that with drugs one can get quick release of feeling or a quick introduction to one's feelings that he has known nothing about before and that somehow this will be beneficial.

What is lacking is a theory to explain how this kind of openness to experience is not the same thing as experience—that the experience has still to be had, and that when an experience is had it still has to be integrated into the personality if it is going to make a difference in a person's life.

*Group practices*—A word about group practices—in the new sensitivity training, the encounter-groups, and the like. Some good things happen in groups and people have had good experiences in them, but there are some situations in which they approach charlatanry and lead to a parody of genuine human relations. I am skeptical of sensitivity training because I have know instances in which the operation was carried out by people who knew some formula about group processes but had no sensitivity to individuals. Individual persons could suffer while apparently the group as a whole was doing well.

There seems to be a conviction that a situation that can release emotion rapidly is good or that having any experience in a group will be a good thing. This is not necessarily so. Just expressing emotion or being primitive is by no means the same as being liberated emotionally. To sustain whatever is gained from some emotional experience, it must be thought about and talked about—integrated with some kind of intellectual process if it is to be sustained.

*Anti-intellectualism*—I refer, for example, to those young people who feel excluded from the group the moment an effort is made to have a rational discussion. I encounter young people, and middle-aged people, who feel that intellectual distinctions are wrong and antidemocratic and will lead to social distinctions or exclusions.

What is happening here is a revolt against the emotional starvation that most people get in school. The answer to the segregation of cognitive processes from the rest of the personality is not segregation of emotional processes from the rest of the personality. The answer must be new efforts to integrate the two so that we can be passionate about intellectual ideas and intellectual or at least rational about emotional experiences.

*Theory about the whole person*—The neglect of the whole person is due to vast and possibly irreversible processes. I do not see how we can make progress without being guided by some theory of how the individual develops in interaction with society. I am assuming, of course, that the individual and his development is the supreme value in our society. We must have a theory about the whole person, including the most essential ideas from psychoanalysis—the idea of the dynamic unconscious and the idea that the same behavior can have a diversity of meanings. I believe we are not far from having such a theory.

This theory must be a social one. It must deal with the ways in which personality develops in interaction with society. It will not do just to have a theory of "socialization." We must see that it makes a difference whether the social stimuli are incorporated into the super-ego or whether they are incorporated into the personality on the basis of the good judgments that take place in the ego itself.

Suppose we have such a theory. The question is how to teach, disseminate, and use it as a basis for practice. It will not do just to exhort people, and I do not know of any powers-

that-be that can be appealed to in the interest of bringing about the teaching of this kind of psychological and social theory. One thing that we can do is to take advantage of the counter forces that develop outside the major systems, as in a school of public health that teaches psychological and sociological theories no longer taught in departments of psychology and sociology because they are unfashionable.

We could try to organize research around problems and people rather than around variables, disciplines, or factors. If we could get research organized in this way, teaching would follow because teaching does follow research. If people can be persuaded to do research that requires them to be generalists, their teaching would be generalized. I think we can humanize what we do in the universities and in practical work by bringing together what has been separated in science and in practice—research from action, action from teaching, and teaching from research.

I would mention the possibility of defining and institutionalizing new kinds of social roles, but this is difficult. Many students would like to be generalists, but they ask themselves, "What would this do to my career?" We are hard put to give them a good answer.

It occurred to me that we might try to reconstruct and lend prestige to the role of the clergyman. He is in an excellent position to practice community psychology, and if we can offer the right kind of training and give his role the prestige that it might have, this would be a way to proceed with actions that really accent the person.

There is no way to halt our advancing technology. We can't just drop out and admit defeat—we might miss some excitement if we do—and besides there is no place to go. We can only be ourselves, and find that we are being human when we try to understand what is happening to us, and to stand in opposition if we don't like it. Without underestimating the power of technological trends, there are some potent forces on our side. Man does not really want to be dehumanized, as we see in each new generation of students who bring the same curiosity and hopefulness and idealism that the last generation brought.

# The Role of the Telephone in the Psychiatric Interview

ROGER A. MACKINNON and ROBERT MICHELS

The telephone plays an important role in psychiatric practice. Although the topic seems simple and straightforward, it involves an area of clinical work and should be subject to study.

### The Patient Telephones the Doctor

*The initial telephone call*—Most psychiatrists expect some information concerning the patient before the first appointment. Often this is provided by the referring physician, but not infrequently a person whom the psychiatrist does not know requests an appointment. If this person does not volunteer information, the doctor will determine if the caller is himself the patient, and how he obtained the physician's name. In gathering this information the doctor develops clinical "hunches." The paranoid patient may ask if this is really Dr. Jones, or whisper, or make references to delusional material; the obsessive patient often attempts to control the doctor by suggesting a list of times when he would be available, etc.

*Calls following the first interview*—Different issues are involved when the patient telephones the doctor following the first visit. Something discussed may have upset the patient, and if this is not explored, the patient might be frightened away. Or the patient telephones because he feels that he "got away with something" during the session. Such comments indicate that the patient was dissatisfied and may have felt that the doctor did not understand him. The physician might comment that the issue could be explored. Another patient may "confess" information which he was unable to disclose face to face.

Phobic patients frequently telephone, expressing a desire for reassurance. The physician could remark, "Something must have upset you; this is not unusual, and your anxiety will pass." It is essential to offer this type of reassurance.

Covert hostile reactions are evident in the patient who calls to say, "This is Miss Smith, the patient that you saw on Thursday morning at 10:00." The implication is clear that so little emotional contact was made that the doctor might not remember the patient. The interviewer may choose not to respond until the next interview. Or, he may ask, "Do you feel you made so little impression on me that I do not remember you?" A less challenging comment would be, "Yes, of course, I remember you."

At the first interview, a patient may ask the physician for his home number. The patient might be asked if he is anticipating an emergency; the doctor could explore what emergency he expects and how he has coped with such situations in the past. The psychiatrist should tell such patients that his answering service is able to contact him in an emergency. Depending on the physician, the answering service will offer his home number when the patient calls or will telephone the doctor, who will return the call. We subscribe to the minority view which favors patients' obtaining the number directly. This implies that the psychiatrist is not afraid of the patient's dependent needs, nor will he feel troubled or bothered if the patient has an emergency. Our experience has been that patients rarely abuse the doctor's privacy.

Severely depressed or suicidal pa-

Condensed with permission from *Psychiatry*, 33(1):82–93, 1970.

tients are often so fearful of being a burden that they need permission to ask for help. The psychiatrist may provide this permission by giving his number to the patient. However, if he gives his number because of his own insecurity and anxiety, he may precipitate a crisis.

Some patients interrupt the doctor with calls to demonstrate their hostile and inconsiderate personalities. Rather than becoming angry or abrupt, it is better to show consideration. One can say in a polite and friendly tone, "I'm busy just now. Could I call you back in a little while?"

The physician must decide whether to telephone a patient who has missed an appointment. During the initial interviews it is good to telephone the patient under such circumstances. Such behavior indicates a transference problem which requires therapeutic intervention.

When a patient has telephoned, it is helpful to refer to the call in the next session. The patient can then discuss his reactions to the conversation and explore its deeper meaning. With seriously ill patients, this uncovering may be deferred until late in treatment.

### Telephone Interruptions During the Interview

Interruptions can be considered in terms of their effect on the ongoing interview rather than upon the relationship between the doctor and patient who is calling. Many doctors never accept telephone calls when they are with a patient. This has advantages and disadvantages. The interviews are never interrupted. However, not accepting calls caters to the infantile omnipotence of the patient, encouraging his fantasy that he is the only person of concern to the doctor. Some doctors permit the patient to hear the ring. They may continue with the interview, ignoring the telephone. The patient is less likely to comment on the distracting influence of the telephone if the doctor ignores it, but he still may be disturbed.

Other psychiatrists have an arrangement whereby they may turn off the bell, allowing a light to flash, with the light visible only to the doctor. It is then possible for the doctor to accept calls, depending on the patient, situation, and his own mood. If the physician is not accepting calls, it is preferable that the patient be unaware that the telephone is ringing.

In the treatment of seriously disturbed patients, the physician's telephone conversation can help the patient to improve his reality testing and recognition of emotions. During the first few sessions the patient often shows no reaction to an interruption. In more advanced stages of therapy, reactions become obvious. These responses are manifestations of the transference and are subject to interpretation. Hearing the doctor talk with another person gives the patient an opportunity to experience a side of the physician's personality different from that which is elicited by the patient's personality. In the later stages, this may help the patient achieve a more realistic image of his therapist.

The effects of an interruption depend upon the problems of the patient, the personality of the psychiatrist, and the specific events at the time of the interruption. The doctor who has a thorough knowledge of all the factors can predict his patient's reactions to a given interruption. When he feels an interruption would have an unfavorable effect upon the therapy, he can turn off the telephone.

*Patient's reactions to the interruption*—Patients may experience *relief*

after interruptions. They may discover that other people have problems similar to their own. The doctor's willingness to accept phone calls from others gives permission for this patient to call the doctor. A third feeling is the reaction which a patient described as "saved by the bell," which occurs when the patient has started to discuss difficult material. The interviewer might explore the feelings underlying the patient's surprise at learning that others have similar problems. Similar exploration would be indicated when the patient is relieved to learn that it is permissible to call the doctor. The patient who feels "saved by the bell" is using the call as a method of resistance. The doctor can direct the patient back to the comments he was making when the telephone rang. It is useful to explore the patient's feelings of relief at the interruption.

The typical *"distracted"* response is characterized by the question, "Where was I when the phone rang?" Such a reaction indicates resistance. Compulsive talking, which superficially resembles free association, may be used as a defense. After the call the patient attempts to reconstitute his defenses by resuming his previous discussion. Rather than exploring resistance, it is useful to ask the patient what he was doing while the telephone conversation was in progress.

Frequently it is appropriate for the physician to say nothing, giving the patient opportunity to pursue his free associations. During the initial history taking, the doctor might ignore an interruption and help the patient to continue with what he had been saying. The therapist must exercise care in following this course since the "simple distraction" is frequently a defense against anger or curiosity about the telephone conversation.

*Angry* responses include direct statements and sarcastic remarks, "Can't you afford a secretary?" or, "You owe me three minutes." It is important that the interviewer not respond with anger or defensive behavior. The doctor either listens while the patient ventilates his rage and then continues, or interprets the patient's feelings that he is being deprived of the interviewer's complete attention. If the call lasts more than a minute, the interviewer might ask the patient if he could stay a few minutes longer.

An example of *denial* is the patient who ignores the call. This response conceals the patient's anger or interest in every detail of the conversation and fantasies concerning the call. Some patients will use fantasy formation to avoid overhearing the conversation. Such denial is a defense against expression or forbidden impulses. The denying patient manifests a striking lack of distraction and it is useful for the interviewer to comment, "You seem not to have been distracted by the telephone call." If the patient denies it, the interviewer could comment, "It's interesting that you were able to keep your mind on the very word you had started to say." If the interviewer successfully uncovers the patient's resentment, the focus of the interview is shifted to this issue.

Responses of *guilt* or feelings of *inadequacy* reveal that the patient has listened to the conversation. These responses stem from anger which the patient turns inward. Because of this profound sense of inadequacy he feels that he has no right to complain. Therapists are tempted to interpret the patient's underlying resentment and usually encounter failure. It is more helpful to comment to the patient that even in his illness he seems to feel that he is a failure—his symp-

toms are less interesting or his case less challenging than that of someone else. The patient who reacts in this manner suffers from hidden feelings of competitiveness. His response to the interruption provides an opening for discussion of such feelings.

The *envious* or competitive response is a variation of the overtly angry reaction. The patient may ask, "Why can't you be that way with me?" The interviewer should not attempt to defend himself or convince the patient that he is not being deprived. Instead, he might encourage the patient to express his feelings of deprivation.

A *paranoid* response would be, "Were you talking about me?" or, "Was the call for me?" The interviewer will learn more if he does not hasten to correct the patient's misinterpretation. He might explore the patient's fantasy and determine the process through which the patient came to his decision. A call may be about the patient. It is wise to indicate to the patient the identity of the caller as soon as the interviewer has determined who is calling, by addressing the caller by name and then proceeding with the conversation. This helps the patient to recognize that the physician is not willing to hold "secret" discussions.

*Curiosity* is a response in which the patient has no awareness of any conscious emotional reaction, "Was that your wife?" or, "Is everything all right at home?" The curiosity is usually a defense against a deeper emotional reaction, such as residual childhood curiosity concerning parental bedroom activities. Rather than answer such questions, it is better to establish with the patient that he does have curiosity concerning such material.

The *sympathetic* response is elicited when it becomes apparent that the caller is in distress. The patient in the office may comment, "I hope that person will be all right," or volunteer to relinquish his appointment. Such reactions are frequently defenses against angry, envious, or guilty feelings. Interpreting the emotion is difficult; the therapist can do little except continue the interview. Perhaps he may thank the patient for his good intentions.

When it is appropriate for the physician to express anger to the "caller," the patient in the office may react with *fear*. An illustration occurred when an insurance agent interrupted a psychiatrist for the third time. The patient appeared shocked, "You certainly weren't very nice to that person!" Patients who inhibit their own aggression often fear that they might lose control and cause injury to others. A variation might be characterized by the patient's disappointment in the doctor. The physician might cope in different ways, interpreting the patient's disappointment that the physician is not perfect, or helping the patient to recall experiences of disappointment in persons he admired.

The patient is sometimes *pleased* with the way in which the doctor conducts himself on the telephone. He may experience vicarious pleasure hearing the doctor express his anger in a way which the patient is unable to emulate. The doctor could direct the interview toward the patient's characteristic ways of expressing anger, and attempt to uncover the fears which prevent him from an open type of emotional expression. Another situation occurs when the doctor has received good news. This reaction would require discussion only if it was apparent that the patient was insincere.

*The interviewer's reactions to the interruption*—It is important that the interviewer be aware of his emotional reactions. He may experience relief

from boredom or relief if the patient has been expressing hostility, or be distracted and experience guilt feelings, or react by feeling happy or sad. He may become angry as a result of the interchange with the caller, or because of the interruption, or because of the time at which the interruption occurred. He can recognize countertransference: as, when he has used a call in order to enhance his status in the eyes of the patient.

On rare occasions the interviewer may ask the patient to leave the consultation room. An example would be a call involving a serious emergency in the personal life of the physician. The doctor would place an undue burden upon the patient by disclosure of his personal problem.

Someone seeking to reach the patient may call. If the patient is in the office, the doctor can hand the telephone to the patient. Should the patient not be there, he may take the message and convey it to the patient. If the matter was not sufficiently urgent to warrant the interruption, the doctor could analyze the patient's motivation for allowing such behavior from friends or relatives.

The patient may ask to use the telephone. If the request would cause the doctor to be late for his next appointment, it could be suggested that the patient call elsewhere. If the request is made at the beginning of the session, the doctor might permit the call but direct the patient's attention to his reasons for not locating a telephone before his appointment. The use of the doctor's telephone can be therapeutically valuable. A patient phoned her broker, placing "buy and sell" orders in an arrogant manner. Before the interviewer could comment, she volunteered, "Doctor, you have observed a portion of my personality of which I am ashamed—I hope you will be able to help me."

*Telephone calls from patient's relatives*—Relatives may telephone and ask for an appointment or for information concerning the patient. Information concerning the patient should not be divulged, but the relative could be told, "I would like to tell John you expressed an interest in his problem." The relative may ask the doctor not to reveal the call. If the doctor agrees, he is placed in an untenable position and therapy is damaged. The therapist may suspect that the caller wishes to interfere in the therapy. We consider it an error to refuse to speak to him if he is close to the patient. Alienating such persons can only injure the patient. If the patient consents, an interview with the relative could be arranged with or without the patient.

**Telephone Emergencies**

A patient may telephone the doctor in a state of serious depression or acute anxiety. Some physicians insist that the patient come for a personal examination or they refuse aid. Such rigidity limits a physician's usefulness. The patient is aware that a personal interview is preferable to a telephone call. In an emergency, a brief positive contact with the physician may be of lifesaving benefit. It is essential that one respond with the same respect and dignity shown in a personal interview.

The physician might begin by obtaining the patient's name, address, and number, if the patient has not identified himself. The patient may be reluctant to provide this information. In this situation, the patient can be asked why he feels it is necessary to conceal his identity. The "telephone" patient has often had prior contact with a psychiatrist. It is useful to ask about such contacts, particularly with the patient who refuses to disclose his identity.

After obtaining a description of the problem, it is useful to ask the patient if he has considered a personal interview. If it is apparent that the patient is psychotic, the doctor can ask if the patient fears that a visit might lead to hospitalization. The therapist might then investigate symptoms which the patient feels might require hospital treatment. It is frequently possible to assure the patient that these symptoms do not require hospitalization. Such a patient can be told that treatment requires the cooperation of the patient. The doctor may assure the patient that he seems to have some motivation to receive help since he has called a physician.

Patients resort to telephone interviews for various reasons. Physical distance prevents some patients from coming in person. Other motivations are the fear of inordinate expense associated with psychiatric help or fear of discussing embarrassing material face to face. Some patients experience such intense desire to commit suicide that they fear that they may not live long enough to be interviewed in person.

On rare occasions, at the conclusion of a long telephone interview the doctor realizes that a patient who refuses to come for an appointment needs help. It may be useful to make an appointment for a second telephone interview. After several such interviews, the patient usually will be willing to come in person.

If someone other than the patient calls it is necessary to determine the relationship between the patient and the person on the telephone.

A doctor may summon the police in response to a call from a severely suicidal or homicidal patient. This should be done openly. If the patient objects, the physician can increase the patient's responsibility, pointing out that he made such action possible through the disclosure of his name and address.

If the patient refuses to disclose his name and address, the doctor might comment, "You must have some uncertainty concerning your wish to die or you would not have called me. There are only a few minutes in which you can change your mind. It may be too late to save your life, but we can try." Realizing that the outcome is uncertain, the patient may allow "fate" to intervene and provide the identifying data. An analogous situation could occur with the patient on the verge of homicide.

A special problem is silences, which occur as they do in conventional therapy. It often is difficult for the interviewer to allow these silences to develop during the conversation. Only through experience can a therapist relax and be professionally at ease while conducting a telephone interview.

The physician may inquire if there is anyone else with whom he can converse; by obtaining another person's view of the patient's problems, the therapist may gain information that would help him to assess the situation.

### Conducting Regular Therapy Sessions by Telephone

On rare occasions a psychiatrist may treat his patient by telephone. For instance, a patient might be forced to move to another part of the country where psychotherapy is unavailable. Under these circumstances, regular treatment sessions might be continued by telephone.

Three brief vignettes illustrate some major points:

A middle-aged depressed woman who had had several years of therapy went to Nevada for 6 weeks to obtain a divorce. Her treatment was successfully conducted twice a week for 6

weeks on the telephone. A 30-year old depressed woman with anxiety and hypochondriacal trends became pregnant and seemed likely to miscarry. Her obstetrician insisted that she remain in bed for 3 months. The psyciatrist treated her twice weekly by telephone during this period. The third patient was a 30-year old phobic housewife. One day a severe snowstorm forced a cancellation. The patient waited until her appointed hour to telephone, as she had hoped to find transportation. The physician sensed that she was eager to terminate the call and commented to that effect. The patient revealed disturbing thoughts about the doctor which she had suppressed while in the office. Subsequently the patient sought a "telephone" session when more difficult material emerged. That time the physician refused as it was clear that the patient's request was a form of resistance.

Admittedly, these are all special situations, but nonetheless they are not unique. The arrangement to continue a patient's treatment by telephone implies that the patient's dependence upon the doctor is realistic. In situations where this would be undesirable, telephone sessions are not indicated.

The telephone consultation presents many challenging and difficult problems. The physician who has developed skill and flexibility in this situation will be able to work more effectively with a wider variety of patients.

# Quasi-Sensory Communication: An Investigation Using Semantic Matching and Accentuated Affect

William M. McBain, Wayne Fox, Susan Kimura, Miles Nakanishi, and John Tirado

Can humans communicate without the use of known sensory channels? We wondered whether it would be possible to design a study acceptable to proponents and opponents of ESP, while attempting to relate the alleged phenomena to the general body of psychological knowledge and procedure. The term "quasi-sensory communication" (QSC) was coined to indicate that the phenomenon acts "as if" a sensory channel were involved, though no such mechanism is known to exist.

The QSC hypothesis might be stated: If Individual A has access to information not available to B, then under certain circumstances, and with known sensory communication channels rigidly controlled, B can demonstrate knowledge of the information available to A at a level incompatible with the alternative hypothesis of chance guessing. We postulated that QSC was based on an ability, not a special psychic "gift," distributed throughout the population in relatively normal fashion, and exhibited in varied degrees in even a small sample. The supposition that such an ability exists raises many problems. Why is it manifested so rarely? One possible answer is that what we identify as abilities are skills which, because of opportunities offered by the culture, have been developed to a terminal plateau. Our culture provides little positive reinforcement for the demonstration of parapsychological skills.

Any such capacity must have been associated with the survival of the organism. Tentative ESP findings suggest that its functioning is less limited by distance than are the recognized senses. This might be an advantage in an era of nomadic, extended family groups thinly populating vast areas. As the population became dense the "noise" level must have become deafening, while as communal living became the rule, this type of sensitivity became less advantageous. One can imagine an involuntary choice of the security of communal living at the expense of suppressing the community background noise.

An organism, even though it possesses means of vocalizing and adequate auditory organs, may be restricted in the range of information it can transmit. Most infrahuman vocalizations carry messages that are nonabstract and emotional. One would hardly expect an untrained chimpanzee, or human infant, to differentiate aurally between the digits 3 and 9, or to transmit to its equally untutored cage- (nursery-) mate the information, "The nice man is holding a card with a star (three wavy lines) on it." If ESP is based upon primitive capacities, the optimum material for transmission should be different from that used in typical experiments. One may arrive at the same conclusion by examining anecdotal accounts of telepathic occurrences. The majority are characterized by the closeness or rapport of the participants and the affective nature of the materials. In the laboratory we must transmit material of an emotional nature between individuals sharing some common basis for its

Condensed with permission from the *Journal of Personality and Social Psychology*, 14(4):281–291, 1970.

interpretation. We must select pairs of subjects with some form of rapport or common basis for communication in the affective area, and provide materials for transmission that are compatible with this requirement. We must also eliminate the possibility of using normal sensory channels of communication, guard against error and dishonesty, and convince critics that our statistics are appropriate.

For purpose of comparability with material already published we adopted the General Extra Sensory Perception (GESP) procedure. One individual (the sender) is exposed to one of five symbols while kept from all possible known physical methods of communicating with a second individual (the receiver), who must guess which symbol has been exposed.

How is it possible to secure pairs of subjects showing rapport, while preserving a sample relatively unselected for QSC ability? The semantic differential technique offered an oblique approach. This technique offers a means of scaling the connotative or affective dimension of meaning. It should be possible to find persons in a normal group who have acquired common affective reactions to the same concept.

Can some method be found for accentuating the affective reactions in the experimental situation? Use of posthypnotic suggestions to accentuate affect has been demonstrated. It seemed justifiable to use suggestion to enhance rapport and increase the confidence and concentration of subjects.

Physical separation of sender and receiver was the most adequate answer to sensory cues, while automated procedures confirmed by permanent records should meet most of the objections based upon human fallibility.

Subjects came from a group of 77 volunteers, almost all from an introductory psychology class. They were asked to volunteer their time to find if they were suitable for an experiment in which "ESP and hypnosis are involved." This number was reduced to 41 by a modified Hull Body-Sway test, which was followed by the Stanford Hypnotic Susceptibility Scale (SHSS), Form A. The 19 subjects with plus scores on the posthypnotic item of the SHSS were augmented by the five highest scorers on the total scale. These 24 potential subjects were semantically matched to form 11 "teams," with the two unmatched subjects dropped from the experiment. Three male-male (M-M), three female-female (F-F), and five male-female (M-F) teams were involved.

To serve as the basis for communication, 23 concepts were selected which seemed likely to evoke emotional reactions and which could be symbolized by line drawings. Six scales were averaged to yield an *evaluative* factor for each concept, while three scales contributed to the *potency* factor and the remaining three to the *activity* factor. When analyzed by computer, this method gave three average factor scores for each of the 23 concepts, or 69 scores for each subject.

Each subject was matched with each other subject by calculating the mean of the squared differences between each of the 69 average factor scores on all concepts. The final selection of pairs was made on the basis of two criteria: desirability of having the lowest mean index of matching possible and of having a balanced team composition by sex.

The five concepts for each team were selected from computer data. The mean-square of the differences between factor scores of the partners was computed. For the 12 best-matched concepts, a midpoint was

obtained between the two partners' values on each of the three factor scores. These concepts were physically plotted in three-dimensional space. The five which appeared most widely spaced, and most likely to be reliably discriminated affectively, were the concepts selected for communication between the team members. Twenty of the 23 concepts were used, as shown in Figure 1.

The apparatus consisted of a display for the sender, a response console for the receiver, a programing device to transmit the planned stimuli to the sender in the correct sequence and at the correct time, and a six-channel event recorder to make a permanent record of the stimulus presented to the sender and the response of the receiver.

The sender, the experimenter, and apparatus except the receiver's console were in one room, which was separated from the receiver's room by a door, a 3-foot corridor, and a double wall.

The sender's display consisted of five translucent panels arranged horizontally, each bearing the symbol and name of one concept on which the team had been matched. The symbol could only be seen by the sender. The sequence was controlled by a punched paper tape, while the length of the exposure and of the period in which the receiver signaled his choice was regulated by a synchronous timer. The beginning and end of each exposure period for the sender, and response period for the receiver were signaled by single strokes of polarized bells.

The study was carried out in three

FIGURE 1—Symbols and Concept Names Used as Stimuli.

1-hour sessions for each team. During the first, subjects were given posthypnotic suggestions, after which each sent and received 25 symbols. In the following two sessions each alternately sent and received two blocks of 25 symbols, a total of 125 symbols sent and received by each during the three sessions.

The completion of the posthypnotic suggestions and the first QSC trials in one session was made possible by modifying the SHSS to include a posthypnotic suggestion for rapid hypnotic induction should the subject continue in the experiment. This made it possible to rehypnotize both members of the team simultaneously. During this process subjects were asked to look at the symbols of the concepts on which they had been matched. For each symbol suggestions were made that as sender the sight of the symbol would cause the subject to feel very strongly the emotion that the concept evoked, while as receiver he would be aware of his partner's emotional reaction to the symbol. Suggestions were given as to the subject's ability to concentrate on his tasks, the degree of rapport he would feel with his partner, his confidence in his ability to communicate with his partner, and his improvement as a result of experience in this form of communication.

As sender for a trial of 25 concepts, the subject had to concentrate on each symbol in turn during the 25 seconds it was illuminated, and to relax during the 5 seconds given the receiver to signal his choice. As receiver he had to decide what concept the sender was concentrating on and signal his choice.

The order of symbol placement was changed systematically on each successive trial of the subject as receiver. Parallel changes were made in the sender's display. Except for two limitations, the sequence of stimulation was determined by a table of random numbers. One limitation was that each symbol should occur an equal number of times in the total sequence. When this condition was not met, the symbols to be excluded and the symbols to replace them were decided by random number tables. Also, if the last block of 25 symbols ended with a run of more than three of the same stimulus, this block should be rerandomized.

To prevent the biasing of guesses by knowledge of the number of symbols in each category already presented or guessed, subjects were informed that while in the total sequence there would be an equal number of each of the five, this would not necessarily be true in any block of 25.

A successful guess was scored only if a response was recorded in the same channel immediately following it. Tapes were independently scored by two experimenters. No information on scores was given to the subject until all had completed the full sequence.

A cogent question in this area has been the motivation of the experimenters and subjects. The history of paranormal phenomena abounds in rogues and charlatans. The initiative for this study came from three of the senior author's students in their last semester of undergraduate work. Their interest had been aroused through his criticism of ESP studies, and was more curiosity than conviction. The importance of a well-designed, tightly controlled study was stressed. These students, and a graduate student interested in solving problems of computer programing, performed most of the experimental work. The senior author designed most of the equipment, gave posthypnotic suggestions, coached experimenters in experimental procedures,

and checked the critical data entries and statistical procedures.

None of the participants could be said to be working under pressure for positive results. The subjects were rather uninvolved, as indicated by the irregular attendance of several. Since no one participating had any reason for dishonesty and/or collaboration, it seems reasonable to assume none occurred.

If the guesses of the receivers in the 22 independent sequences of 125 transmitted concepts had been determined by chance, the frequency distribution of numbers of successful guesses should not have been significantly different from the theoretical distribution obtained from the expanded binomial $(.20+.80)^{125}$. In this case the theoretical distribution may be considered the population, and its mean and standard deviation determined as being $M_{pop}=25$ and $SD_{pop}=4.47$. Since the obtained distribution has a mean of 26.86 and the calculated SE of the population mean is .95, the obtained $t=1.95+$. The hypothesis holds that guesses should be significantly more accurate than chance, making a one-tailed test appropriate, with $p=.025$. However, even by the conservative two-tailed test, $p=.05$.

The purpose of posthypnotic suggestion was to accentuate the affective reactions of subjects to the concepts. If this expectation is justified it is reasonable to suppose that subjects who are most susceptible to hypnosis should show the greatest accuracy. When this prediction was tested, the obtained correlation of $r=.22$ was not significant. However, for senders a highly significant correlation was obtained ($r.=.64$, $p<.01$).

Had the scores of receivers been related to SHSS scores it might have strengthened the suspicion of uncontrolled factors, with the heightened concentration adding to the subject's awareness of such cues. But the relation to the scores of senders is an independent confirmation that success in guessing is not dependent on chance, but is related to characteristics of the sender.

Did the semantic matching have any relation to the accuracy of communication? This was tested in several ways: The number of hits scored by each team was compared to the closeness of their semantic match; within teams the hits on each concept were compared with the closeness of its semantic match; the mean of vectors in semantic space from each concept to the other four was compared to the accuracy of that concept's guessing, both within the team and for all teams; the mean factor ratings of each concept by those using it were compared with their mean success in guessing each concept. None of the analyses produced evidence that the semantic matching had any relation to the accuracy of guessing.

In the makeup of teams some latitude of matching was permitted to allow a symmetrical design of team sex makeup. This took account of the possibility that sex-differentiated socialization practices might affect the subjects' perceptions of a concept, hence the accuracy of communication.

Mean team hits were compared with team sex composition, as follows: M-M, 60.7; M-F, 47.8; F-F, 56.7. Because the like-sex teams did not differ significantly, their results were combined. Clearly, like sex teams are to be preferred for QSC.

Some interesting trends emerged from the questionnaire data. They should be considered tentative because of the small number of subjects. It has been asserted that believers in ESP are more successful. Since all subjects in our study had been re-

cruited through their interest in ESP, it was not surprising to find they had all indicated their belief that ESP was "possible," "likely," or "proven." There appeared to be no difference in the hit records in these three categories when acting as sender. When serving as receivers, persons who answered in the first and last categories showed much better performances than those answering "likely."

If one were attempting to select superior subjects, one might hope to do this from subjects reporting previous experiences of ESP. Another $\chi^2$ analysis was performed to compare the hit records of those who reported having such experiences "regularly," "frequently," or "from time to time" with the records of those who reported "rarely" or "never." While receivers showed no difference between the two classes, senders who reported in the latter categories did significantly better than the others ($\chi^2=4.14$, $p<.05$). It is worth noting that all senders in the latter categories were above the general mean, while none reporting regular or frequent experiences scored above that level.

A final unanalyzable observation is that of three subjects reporting ESP abilities in close relatives, only one exceeded the mean level of hit as a receiver, none as a sender.

Even if the concept of QSC has no validity whatsoever, in 1,000 replications of our study significant deviations from the theoretical chance distribution might be expected in 25 (or 50) cases. These would be the cases reported, since most psychologists consider negative results in this area hardly worthy of note.

Selective reporting of positive results confounds rigid interpretation of significance levels in any investigation, but marginal results in a controversial field should be viewed with caution. It should be pointed out that in the distribution of hits only one of the 22 records with a score of 35 fall beyond the 5 percent confidence interval. Lacking that record, the distribution could be attributed to chance.

If the distribution of hits were determined only by chance it could not be expected to relate significantly to any other variable. It has been demonstrated that the dependent variable relates to the hypnotizability of the sender and the sex composition of the team, as well as showing the more tentative relations to personal data. It seems unlikely that such a complex set of interrelations could be the result of chance.

To attribute results to lack of control over normal physical channels of communication is difficult. It would take great ingenuity to suggest a sensory mechanism which would favor more over less hypnotizable senders, like-sex over unlike-sex teams, and still be undetectable by four experimenters in the same room as the sender during 33 1-hour sessions.

While errors are possible, the nature of the experimental precautions, the simplicity of the computational routines, and the checking of findings by alternative methods make this explanation unlikely. The same precautions minimize the likelihood of trickery. The rather even spreading of surplus hits to give such a pattern over several sessions would call for considerable collaboration and a higher level of statistical sophistication than the senior author cares to claim.

Though it would be presumptuous to suggest this study has demonstrated the existence of QSC, the exclusion of commonly accepted alternative explanations for the findings should help to justify continued investigations in this area.

# Freud's Case-Load

BENJAMIN BRODY

Probably more than other science, psychoanalysis is the creation of a single man. The clinical experience, social ideology, and perhaps personal idiosyncrasies of Sigmund Freud are the cornerstones of analytical practice and theory. A careful examination of the cultural, psychological, and clinical bases of Freud's thinking seems imperative for an evaluation of the validity and limitations of his conclusions.

Freud's clinical writings give only a small and selected sample of his case-load, but they possess a unique value. It seems reasonable to assume that they represent those cases which stimulated Freud sufficiently to motivate him to a full report or passing reference.

The case-reports range from clinical histories containing a relatively complete anamnesis, some record of the therapeutic process, and a theoretical discussion to the barest mention of a patient in connection with a single point. Even in the most detailed account it is frequently difficult to ascertain the kind of vital statistic in which we are interested, perhaps because of the need for professional discretion as well as a literary predilection that frequently obscures the presence of factual life-history material. In the famous Wolf-Man case, some rather involved calculation is necessary to establish that the patient was about 23 years old when he came for treatment. Freud frequently conducted arm-chair analyses of literary and historical characters, utilized case-material offered by colleagues or from his personal life and non-clinical observations, and, on at least one occasion, constructed an ideal-type case for illustrative purposes.

To obviate these difficulties, only patients whom Freud personally treated are considered. The case material is divided into major and minor categories. The major category is composed of those cases that are several pages long, include some statement of the patient's life circumstances, and serve as the vehicle for a theoretical discussion; the minor cases are the remaining ones.

The cases were analyzed in terms of sex, age, marital state, diagnosis, and social class. Freud provides fairly accurate information on the first four variables though it is frequently incomplete and occasionally requires reconstruction from the available evidence.

The situation is different in relation to social class. Though realizing the fact of social stratification, Freud rarely identified his patients as belonging to one or another status hierarchy. By a systematic, empirical evaluation of such information as occupation, source of income, education, religion, and ethnic origin, a statistically valid estimate of social status can be computed. Thus, the Wolf-Man was of at least middle-class status because of the references to his family estates, nurse, and English governess. Similarly, Dora's extensive education and her father's position as "a large manufacturer in very comfortable circumstances" place her in the middle-class group.

Freud's complete works were analyzed; 114 papers were searched for major and minor cases and all 22 books were examined for major cate-

---

Condensed with permission from *Psychotherapy: Theory, Research and Practice*, 7(1):8–12, 1970.

gory alone. About half of both the major and minor cases were published from 1889 to 1900, a period that is equivalent to the first stage of psychoanalytical development, and that ended with Freud's involvement in the intricacies of instinct psychology. The decrement in number of case presentations after 1900 is associated with the development of the libido theory. It seems clear that Freud's interest in people and their relationships diminished around 1900 in favor of constitutional factors. In the 1920's, during the period of pessimism about the efficacy of psychoanalytical therapy and the first experiments with therapeutic technique, Freud published no major cases and comparatively few minor cases.

*Sex*—Women composed about two-thirds of Freud's published cases. In spite of his case-load, Freud, like many contemporary classical analysts, confessed difficulty in formulating the psychology of women. As late as 1924, in discussing psychosexual development of girls, he says: "Here our material—for some reason we do not understand—becomes far more shadowy and incomplete." On the basis of a clinical practice largely devoted to women, Freud derived a male psychology.

*Diagnosis*—Freud diagnosed six of his 12 major cases as hysteria, four as obsessional neurosis and phobia, and one each as homosexuality and paranoia. These proportions are maintained in the minor group; about 65 percent have, as their primary diagnosis hysteria and obsessional neurosis, 15 percent anxiety neurosis, and the remainder is divided equally between unclassified neurotic conditions and psychoses. Freud's limited and relatively late experience with psychotic patients may be reflected in his belief that they are incapable of transference and hence not amenable to analytical therapy.

*Age*—Nine of Freud's major cases were between 18 and 20 years of age, only two were older than 30, and only one was a child. These trends are maintained by the minor cases. About 90 percent of the total patient group is between 20 and 44. One wonders to what extent his limited experience with older patients is responsible for the dictum that psychoanalysis is not indicated with older people.

*Social class*—Freud's patients were drawn exclusively from the upper and middle class. The insistence of the cultural school of analysis that Freud's conclusions were derived from a limited social group is confirmed. In all probability, this is true of present-day American analysis as well.

*Marital state*—Seven of the 10 adult major cases were single in contrast to only 22 percent of the minor ones. The significance of this difference should not be overestimated because of the small number of cases in the major category. In the minor group, about 85 percent of the female patients were married, and about 55 percent of the males were. Though the evidence is not clear, it seems probable that a majority of Freud's patients were married.

## Heroin and Human Sleep

S. A. Lewis, I. Oswald, J. I. Evans, M. O. Akindele, and S. L. Tompsett

It has been suggested that all common drugs of addiction cause reality escape, initial suppression of REM sleep and after their withdrawal, a rebound excess of REM sleep. There has been little study of the effects on sleep of the "hard" drugs of addiction, morphine and heroin.

The first four authors, all healthy males, were subjects. Sleep EEGs and electro-oculograms (EOGs), two channels of each, were recorded. Recordings were made on three consecutive nights after 7.5 mg subcutaneous heroin administration and then three subsequent withdrawal nights. Two subjects (I.O. and S.A.L.) were recorded on several occasions over the next 2 months, after which they received 7.5 mg heroin subcutaneously on seven consecutive nights, during which sleep records were obtained each night. The first seven withdrawal nights were recorded, and recordings were obtained intermittently over the next 2 months for one subject (I.O.) and 3 months for the other.

Heroin immediately decreased the proportion of REM sleep in the whole night. Despite continued nightly administration of heroin there was a gradual restoration to predrug levels, though over the period of three nights restoration was incomplete. On withdrawal there was an immediate rise in the proportion of REM sleep. Whole-night REM sleep was not significantly different from its predrug value but over the first 3 hours of sleep there was a significant REM rebound compared with baseline nights during withdrawal.

The administration of heroin was accompanied by an increased amount of stage 1 sleep and an increased number of shifts to stage 1 or wakefulness in the first 3 hours of sleep. Similar effects were found with subjects I.O. and S.L. during the second series of heroin injections. Associated with this increased sleep was a significant increase in the delay to sleep onset. Stage 2 and stages 3 plus 4 were not significantly affected but stage 2 in the first 3 hours of sleep was significantly increased.

Subject S.L., had not returned to base line 2 months after the first series of heroin injections. However, a reduced percentage of REM sleep and a gradual return toward the base line were observed for both subjects during the week of heroin administration. Heroin withdrawal was followed by a marked and immediate REM sleep rebound which declined over about 3 months in one subject (S.L.). The other showed little evidence of REM sleep rebound.

The results indicate that, whatever the behavioral appearances, sleep is disturbed by heroin. The results from the two subjects in the second study would indicate individual differences in response. Neither subject has ever been addicted to any drug, though S.L. smokes. Neither experienced euphoria on the drug; indeed all subjects found it unpleasant. None experienced withdrawal "craving." However, one may speculate that the marked and prolonged recovery process demonstrated in S.L. could indicate a constitutional difference rendering him more "at risk."

We appear to have demonstrated that the brief administration of heroin can induce abnormalities of human brain function which become apparent on drug withdrawal and which may persist during weeks or months after the withdrawal.

Condensed with permission from *Electroencephalography and Clinical Neurophysiology*, 28(4):374–381, 1970.

# Mental Health and the Law

## Recent Cases

**Thorn v. Superior Court of San Diego County, California Supreme Court, No. L. A. 29678, January 26, 1970**

The new California mental health law of 1969 included provisions as to the right of a patient detained under certification for involuntary 14-day intensive treatment to representation by counsel and to seek release by habeas corpus. Pursuant to this statutory language, in response to an action by Defenders, Inc., a legal-aid type organization, the Superior Court of San Diego County issued an order that unless court-appointed legal services attorneys were admitted to visit all patients involuntarily detained in treatment facilities for the 14-day period, a writ of habeas corpus would be issued to have the patients brought before the court. The court, in reaching this decision, reasoned that involuntary commitment demonstrates the patient's lack of consent to treatment, and thus is tantamount to a request for release.

On appeal, the California Supreme Court affirmed. The Superior Court, it said, acted within its jurisdiction in issuing the order. The court's construction of the statutory provisions, it added, appeared to accord with the legislature's intent and to extend protection to the patient's rights to due process, to counsel, to notice, and to a hearing, if desired. It was appropriate that, in any certification for involuntary treatment, procedures be established to assure meaningful protection for the patient's rights. The view of the lower court that, upon certification, the patient be promptly visited by appointed counsel illustrated one possible procedure, the court said.

Alternatively, the court suggested that counsel be present at the time the notice of certification is read to the patient or when his right to a hearing is explained. A visit by a third person immediately after notice of certification is presented to the committing judge would also achieve the desired result. Any one of these, the court said, would adequately protect the patient. The court was cautious to note that it should not endeavor to set forth rigid procedures for this purpose, but should instead suggest guidelines to aid in carrying out the Act.

**Millard v. State of Maryland, Maryland Court of Special Appeals, January 12, 1970**

Millard's defense to a charge of robbery with a deadly weapon was offered through the testimony of a geneticist who stated that the defendant had an extra Y-chromosome, a mental defect which, he said, manifests itself in marked antisocial, aggressive, and schizoid reactions. Further, he stated that persons afflicted with such a genetic abnormality were prone to crime and were in continual conflict with the law. On the basis of this single geneticist's testimony, the trial court refused to submit the question of sanity to the jury, finding this evidence not sufficient to overcome the presumption of sanity.

On appeal, the Maryland Court of Special Appeals affirmed the decision. The geneticist's testimony that persons having the Y-chromosome abnormality are prone to aggressiveness and antisocial behavior does not, it said, show a lack of "substantial capacity" under Maryland's statutory definition of insanity. The court noted

that it was not rejecting this genetic theory of insanity as beyond "the pale of truth" under the criminal responsibility statute, but was merely concluding that to submit the theory to the jury in this case would have been in error.

**Landlee v. City of Albuquerque, New Mexico District Court, January 16, 1970**

The juvenile had for a period of over 2 months been taking methadone from a licensed physician in an attempt to end his addiction to heroin and be rehabilitated. The juvenile then was convicted of driving with a revoked license, and was sentenced to a 10-day sentence in a juvenile detention center. When the center personnel refused to admit the private physician who had been treating the juvenile with methadone, the mother of the addict sought mandamus to compel admission of the doctor to the facility. She claimed that the withdrawal symptoms that the defendant city and police chief were forcing her son to undergo constituted cruel and unusual punishment, in violation of the Eighth Amendment to the United States Constitution.

The court ordered the local police to let the juvenile's private physician enter the juvenile detention center and continue the prescribed methadone treatment. Although the mother argued cruel and unusual punishment, the court took up that issue only to the extent of noting the uniqueness of a 10-day confinement sentence for a juvenile's traffic offense. To deprive the child of the program he had been on would, the court reasoned, be an unreasonable denial of medical care to him. Specifically, however, the court rested its decision on a State statute that authorizes any licensed attending physician to administer narcotic drugs to a prisoner.

**United States v. Thirty-Seven Photographs, United States District Court for Central California, January 27, 1970**

In Stanley v. State of Georgia, April 7, 1969, the United States Supreme Court held that private possession of obscene material is not a crime. In the instant case, brought by an importer, a commercial publisher of eroticism, the United States District Court for Central California ruled that the First Amendment to the United States Constitution cannot protect the right to "consume" obscene publications at home (the *Stanley* holding) without preserving the right to obtain them. For that reason, the court held unconstitutional a Federal statute which flatly prohibits the importation of obscene books and photographs.

As the defendant in this case was importing the books and pictures not for his private use but for reproduction and sale, the court went on to hold that the only distribution of obscenity that can be prohibited is that which conspicuously forces itself on the general public by offensive promotional display in public places.

Another defect of the law, the court added, is that it provides for immediate customs seizure of obscene matter upon discovery at entry points. This, the court said, is prior restraint, and any censorship scheme involving prior restraint requires prompt judicial determination of the obscenity question, based on an advisory hearing. The statute lacks any effective guarantee of such prompt determination, so it fails.

**New Alcoholism Treatment and Rehabilitation Grants**

The Community Mental Health Centers Amendments of 1968 (Public Law 90–574) and of 1970 (Public Law 91–211) authorized Federal support for comprehensive community alcoholism prevention and treatment services and facilities.

The purpose of staffing grants is to help cover initial costs of compensation of professional and technical personnel of alcoholism treatment programs provided under the auspices of either a community mental health center or a public or private nonprofit organization. Beginning July 1, 1970, Federal support for staffing is available on a matching basis for an 8-year period as follows:

| *Poverty Areas* | *Non-Poverty Areas* |
|---|---|
| 90% 1st and 2nd years | 80% 1st and 2nd years |
| 80% 3rd year | 75% 3rd year |
| 75% 4th and 5th years | 60% 4th year<br>45% 5th year |
| 70% 6th, 7th, and 8th years | 30% 6th, 7th, and 8th years |

Applicants for staffing grants must be one of the following: A community mental health center; a public or private nonprofit agency or organization which will affiliate with a community mental health center before accepting funding; a public or private nonprofit agency or organization located in an area with no community mental health center which agrees to both appropriately utilize existing community resources and to apply within a reasonable time for affiliation with any future community mental health center servicing the area.

An agency applying for a staffing grant must be able to provide the following essential services to alcoholics: Inpatient Services, including diagnostic services; Outpatient Services, including diagnostic services; Intermediate Services, such as halfway house, partial (day or night) hospitalization, or other sheltered care; Emergency Services, providing 24-hour, 7-days-a-week services for medical, psychiatric, and social emergencies; Consultation and Education Services, relating to prevention and treatment of alcoholism.

The applicant also must meet the following: assure coordination of services and continuity of care; be able to show sources of funds to bridge the gap between Federal support and total program costs; serve all persons in the community mental health center geographical catchment area without regard to age, race, creed, national origin, or ability to pay; furnish information to NIMH concerning nature of service provided, characteristics of population served, and evaluation of effectiveness of services.

Additional services which may be provided with Federal matching funds are: rehabilitation services, including vocational, educational, and social services; inservice training programs for all program personnel who provide services to alcoholics; research and evaluation of the effectiveness of the alcoholism services in the light of the needs of the area.

Inquiries and requests for application forms should be addressed to the appropriate DHEW Regional Office, or to the National Center for Prevention and Control of Alcoholism, National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.

(A list of the Regional Offices is available from the Center.)

Draft proposals may be submitted for review and consultation, if de-

sired, in advance of formal submission. Twenty copies of the staffing grant application should be forwarded to the Associate Regional Health Director for Mental Health in the applicable Regional Office.

The CMHC amendments also authorize grants for initiation and development of comprehensive alcoholism service programs, training of personnel to operate alcoholism services, evaluation of service programs, special services projects, and construction of alcoholism treatment facilities. Information concerning these other grants and Federal support for construction will be available later.

**Annual Meeting of the American Psychiatric Association**

At the Annual Meeting of the American Psychiatric Association held in May 1970 in San Francisco, it was announced that the new president-elect is Dr. Ewald Busse, chairman of the Department of Psychiatry at Duke University and director of the University's Center for the Study of Aging and Human Development. Dr. Robert S. Garber, medical director of Carrier Clinic in Belle Mead, N.J. took office as president. Dr. Herbert Gaskill and Charles Prudhomme were elected vice-presidents, Dr. George Tarjan was reelected secretary, and Dr. Hayden H. Donahue was reelected treasurer.

The Association conferred several awards: Dr. Lauren H. Smith, physician-in-chief of the Institute of the Pennsylvania Hospital, Philadelphia, received the Distinguished Service Award. Drs. Arnold M. Ludwig, Jerome Levine, and Louis Stark were awarded the Lester N. Hofheimer Prize for Research for their research on LSD and alcoholism. The Agnes Purcell McGavin Award for outstanding contributions to the prevention of emotional disorders in children went to Dr. Milton J. E. Senn. Jean Dietz of the Boston Globe received the Robert T. Morse Writers Award, which is given to science writers who have contributed to public understanding of psychiatry.

**Community Services for the Elderly**

Syracuse (N.Y.) State Hospital has two programs tailored to the needs of those 65 and over. They are the "710 Irving Avenue Geriatric Unit" and the "Toomey Abbott Center."

When it became apparent that better service could be provided to the elderly if a day care service could be started, a two-family home at 710 Irving Avenue near the Hospital was purchased. The entire catchment area is served. The Unit has several living rooms, a kitchen, and activity facilities, and the staff, or Unit team, consists of a senior psychiatrist, social worker, two nurses, four attendants, an occupational-recreational therapist, and a secretary. The activities include individual and group sessions, kinesthetic therapy, reality orientation, and a rehabilitation program.

The Unit team emphasizes two principles in serving this group of elderly people: there must be adequate transportation facilities so that the service is easily accessible and the families receive attention as well as the elderly participant in the program. Transportation is therefore provided by the Unit. And it is felt that the attention to the participant's family, or guardian, is helpful in preventing hospitalization.

The other program is in Toomey-Abbott Towers, a housing facility for about 400 elderly persons. The center is on the first floor and is open to residents of the facility. It makes extensive use of two volunteer groups—Syracuse University students and two

home economists. The center has developed an "adoptive grandparent program" in which students "adopt" an elderly participant for a year.

The home economists help in rehabilitation, and are especially useful in helping the participants to become more self-reliant.

The program included a research project which includes studies of the morbidity and mortality of the Towers group as compared with a control group under institutional care.

Both are under the direction of Dr. Philip P. Steckler, coordinator of geriatric day care services for the Hospital.

**Encounter Groups and Psychiatry**

The American Psychiatric Association has published a report on "Encounter Groups and Psychiatry." It was prepared by the APA Task Force on Recent Developments in the Use of Small Groups, and is the first of a new series of APA Task Force Reports. The report states that the evidence that encounter groups are dangerous is "meager indeed," but that "in the hands of some leaders, the group experience can be dangerous for some participants." The report may be obtained for $1.50 from the APA Publications Services Division, American Psychiatric Association, 1700 18th St. N.W. Washington, D.C. 20009.

**Toward Therapeutic Care**

A new edition of *Toward Therapeutic Care*, which aims at the improvement of care for the mentally ill through increased clinical competence, has been published by the Group for the Advancement of Psychiatry. The book is the result of a study on nursing care by psychiatrists and psychiatric nurses, and offers help in two ways: brief statement of theory —manifestations of mental illness, suggested patterns of patient care; and clinical application, with 22 detailed case studies.

New in the second edition is a third part that consists of a guide for using the case studies in the text as a basis for training and supervising those who work with the mentally ill.

Copies (GAP Publication No. 77) may be obtained at $3.50 from the Publications Office, Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, N.Y. 10016.

**Mental Health in the Americas**

A conference on mental health in the Americas was held in San Antonio, Texas in December 1968, sponsored by the Inter-American Council of Psychiatric Associations and the American Psychiatric Association. A 23-page bilingual report on the conference by Eugene B. Brody, M.D., editor and program director, has now been published, and is available free from the APA Publications Services Division, 1700 18th St., N.W., Washington, D.C. 20009.

**Black Psychiatrists in America**

*Black Psychiatrists in America* is a new quarterly newsletter sponsored by the Sheppard and Enoch Pratt Hospital in Towson, Md. Information about it may be obtained from the editor, James R. Ralph, M.D., Box 2104, Towson, Md. 21204.

* U.S. GOVERNMENT PRINTING OFFICE: 1970 O—435–719/1

# recent nimh publications

Single copies of these publications may be obtained from the Office of Communications, National Institute of Mental Health, LL02, 5454 Wisconsin Ave., Chevy Chase, Maryland 20015. A complete list of all publications available from the NIMH may also be obtained from the Office of Communications. If a price is given, the publication may be ordered in quantity from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Enclose a check or money order payable to the Superintendent of Documents.

**The National Institute of Mental Health.** This 20-page illustrated pamphlet describes all the programs of the Institute and includes a list of the names and addresses of the Associate Regional Health Directors for Mental Health in the Regional Offices of the Department of Health, Education, and Welfare. National Clearinghouse for Mental Health Information Publication No. 5027.

**Lithium in the Treatment of Mood Disorders.** This is a 105-page comprehensive and integrated account of the results of all major studies evaluating the effectiveness of lithium in a treatment of a wide variety of mood disorders. By Antoinette A. Gattozzi for the NIMH Program Analysis and Evaluation Branch. National Clearinghouse for Mental Health Information Publication No. 5033. 90¢.

**Computer Applications in Psychotherapy: Bibliography and Abstracts.** This 176-item bibliography, including abstracts, covers theoretical approaches and computer usage, sources and methods of data collection, simulation of cognition and personality, interview simulation, group and social process modeling, and content analysis. Compiled by Kent Taylor, National Clearinghouse for Mental Health Information, with a foreword by Kenneth Mark Colby, M.D. of Stanford University. Public Health Service Publication No. 1981. $1.00.

**Bulletin of Suicidology.** No. 6, Spring 1970. This is a special issue commemorating the tenth anniversary of the Los Angeles Suicide Prevention Center. Edwin S. Shneidman, Issue Editor. 65¢.

**Psychopharmacology Bulletin.** Vol. 6, No. 2. April 1970. A special issue devoted to the Early Clinical Drug Evaluation Program of the NIMH Psychopharmacology Research Branch. Prepared by the Psychopharmacology Research Branch. $1.00.

NDH DEC RMP
MAYO CLINIC LIBRARY
200 FIRST ST S W
ROCHESTER MN 55901

HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL INSTITUTE OF MENTAL HEALTH
5454 WISCONSIN AVENUE
CHEVY CHASE, MARYLAND 20015

OFFICIAL BUSINESS

POSTAGE AND FEES PAID
U.S. DEPARTMENT OF H.E.W.

o
w.